Exhibit “B”

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

CASE NO. _____
County Court Case No. 2021-042984 SP-23

LARKIN EMERGENCY PHYSICIANS, LLC, a Florida Corporation (o/b/o Member # 9455159877)

Plaintiff,

vs.

NEIGHBORHOOD HEALTH PARTNERSHIP, INC., a Florida Corporation

Defendant.
_____/

DECLARATION OF JANE STALINSKI

1. My name is Jane Stalinski. I am over 21 years old and make this declaration based on my personal knowledge.

2. I work as a Senior Legal Services Specialist and an authorized representative of UnitedHealthcare Insurance Company ("United") and its affiliate companies including Neighborhood Health Partnership ("NHP").

3. I have reviewed the documents referenced in and attached to this declaration and I am familiar with the business records of United and its affiliates.

4. As part of my duties, I am familiar with and have access to enrollment and member information and benefit plans for individuals who are insured by or an HMO member of NHP.

5. I have reviewed the Complaint filed in the above-styled action. The Complaint provides an NHP member identification number, and the date of service at issue. Based on that

information, I have identified and accessed information and documents related to that member's claim at issue.

6. The attached Handbook for Employees and Eligible Dependents (Exhibit "A") is a true and correct copy of the Handbook for Employees and Eligible Dependents that the employer Human Resources Associates, LLC approved and was in effect on February 12, 2018, the date of service reflected on the claim at issue. Exhibit "A" hereto is kept by NHP in the regular course of business and it is the regular practice of NHP to retain such documents.

Pursuant to 28 U.S.C. § 1746, I hereby declare, under the penalty of perjury, that the foregoing is true and correct to the best of my knowledge, information and belief.

Executed on February 14, 2022.

Jane Stalinski

Jane Stalinski

Exhibit “A”

Handbook For Employees and Eligible Dependents

For

the Plan F0UW

of

Human Resource Associates, LLC

Enrolling Group Number: 909572

Effective Date: November 1, 2017

Offered and Underwritten by

Neighborhood Health Partnership, Inc.

MEMBER HANDBOOK

Please call Customer Service at the telephone number on your ID Card for assistance regarding claims, resolving a complaint or information about Benefits and coverage.

Note: Call Customer Service at the telephone number on your ID card, or check our website www.myNHP.com to determine appropriate providers to contact in the case of emergency and other information regarding emergency services within the community. In some cases, the most cost effective action may be to visit an Urgent Care Center. Check your Summary of Benefits to determine the copayment or coinsurance for a visit to the Urgent Care Center or your Physician's office, rather than seeking care at an emergency room in a hospital.

Our website www.myNHP.com also includes plan details, such as copayments and coinsurance for various services, any required deductible and the status of your maximum out-of-pocket.

Notice: Examine your provider's itemized statements. If you believe you have been billed for procedures or services you did not receive, please notify us. If we determine you were improperly billed, we will reduce the amount of payment to the provider accordingly and we will pay you 20% of the reduction up to $500. This payment only applies in the event you notify us of possible improper billing.

This health benefit plan may contain a deductible.

Neighborhood Health Partnership, Inc.

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IMPORTANT INFORMATION

Neighborhood Health Partnership, Inc.

7600 Corporate Center Drive

Miami, FL 33126

Mailing Address

PO Box 5210

Kingston, NY 12402-5210

Customer Service

305-715-2500

1-877-972-8845

TTY 305-715-2322

Spanish speaking members: 888-414-3245

Monday through Friday between 8am and 6pm

Online directory and member information www.myNHP.com

YOUR RIGHTS AND RESPONSIBILITIES

NHP is committed to provide you with quality healthcare. It is important that you know your rights and responsibilities under the Group Service Agreement (referred throughout this Handbook as the Agreement) and this Member Handbook (referred throughout as the Handbook).

Member Rights and Responsibilities

You have the right to:

- Be treated with respect and dignity by Neighborhood Health Partnership personnel, network doctors and other health care professionals.
- Privacy and confidentiality for treatments, tests and procedures you receive. See Notice of Privacy.
- Practices in your benefit plan documents for a description of how UnitedHealthcare protects your personal health information.
- Voice concerns about the service and care you receive.
- Register complaints and appeals concerning your health plan or the care provided to you.
- Receive timely responses to your concerns.
- Candidly discuss with your doctor the appropriate and medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
- Access to doctors, health care professionals and other health care facilities.
- Participate in decisions about your care with your doctor and other health care professionals.
- Receive and make recommendations regarding the organization's rights and responsibilities policies.
- Receive information about UnitedHealthcare, our services, network doctors and health care professionals.
- Be informed about, and refuse to participate in, any experimental treatment.
- Have coverage decisions and claims processed according to regulatory standards, when applicable.
- Choose an Advance Directive to designate the kind of care you wish to receive should you become unable to express your wishes.

You have the responsibility to:

- Know and confirm your benefits before receiving treatment.
- Contact an appropriate health care professional when you have a medical need or concern.
- Show your health plan ID card before receiving health care services.
- Pay any necessary copayment at the time you receive treatment.
- Use emergency room services only for injury or illness that, in the judgment of a reasonable person, require immediate treatment to avoid jeopardy to life or health.
- Keep scheduled appointments.
- Provide information needed for your care.
- Follow agreed-upon instructions and guidelines of doctors and health care professionals.
- Participate in understanding your health problems and developing mutually agreed-upon treatment goals.
- Notify your employer of any changes in your address or family status.
- Log in to www.myNHP.com, or call *Customer Care* when you have a question about your eligibility, benefits, claims and more.
- Log in to www.myNHP.com or call *Customer Care* before receiving services, to verify that your doctor or health care professional participates in the UnitedHealthcare network.

HEALTH CHOICES - YOUR RIGHT TO DECIDE

All adult individuals in healthcare facilities such as Hospitals, nursing homes, hospices, home health agencies, and health maintenance organizations, have certain rights under Florida law.

You have a right to fill out a form known as an "advance directive." The form stipulates what kind of treatment you want or do not want for special or serious medical conditions. For example, if you were taken to a healthcare facility in a coma, would you want the facility staff to know your wishes about decisions affecting your treatment?

- WHAT IS AN ADVANCE DIRECTIVE?
  - An advance directive is a written or oral statement which is made and witnessed prior to a serious illness and injury. It says how you want medical decisions made. Two forms of advance directives are:
    - A Living Will
    - Healthcare Surrogate Designation
  - An advance directive allows you to state your choices about healthcare or to name someone to make those choices for you, in the event you are not able. For more information, contact Customer Service.

ANSWERS TO FREQUENTLY ASKED QUESTIONS

Q. Who do I call for assistance or if I need information in another language?

A. Our Customer Service phone numbers on your NHP ID Card. Language assistance is available through Customer Service.

Q. Does NHP have a website, and can I e-mail my questions?

A. Our website address is www.myNHP.com. Our website offers helpful information about NHP and your coverage. The NHP homepage offers a useful link for contacting us (click on "contact us"), with e-mail addresses and telephone numbers for other NHP departments.

Q. What is on the NHP webpage?

A. NHP's website provides members with useful tools and guidelines. The website contains Members Rights & Responsibilities Statement, Notice of Privacy Practices, Preventive Health Guidelines, Preferred Drug List, Behavioral Health Benefit Information, and Provider Lookup. If you would like a summary of the tools and/or guidelines, please contact Customer Service at the phone numbers on your NHP ID Card.

Q. How do I order a new ID Card, change my Primary Care Physician (PCP) or order a new Provider Directory?

A. Please call Customer Service at the phone numbers on your NHP ID Card or access www.myNHP.com.

Q. How can I add a dependent to my NHP coverage?

A. You need to coordinate adding dependents through the HR department of the employer group through which you are covered. Your HR department can provide you with an NHP enrollment form. There are special rules regarding when dependents can be added. Your HR department can help you with this.

Q. How do I obtain a referral?

A. Unless your health benefit plan includes a Direct Access Rider, you must coordinate all of your care through your PCP. You will need a referral from your PCP to visit a NHP specialist. However, you may access the following specialties without a referral from your PCP:

- Podiatry
- Chiropractic
- Dermatology (first 5 visits)
- Gynecology
- Alcohol/substance use treatment (services must be provided by NHP's Behavioral Health Network)
- Mental Health (services must be provided by NHP's Behavioral Health Network)

Q. What is included in a referral?

A. A referral is a written recommendation from your Primary Care Physician (PCP) for you to see a specialist or receive certain healthcare services. Your PCP must issue the referral through NHP's automated referral system or by contacting NHP directly prior to your visit. Please discuss with your practitioner the tests and services which are included in the referral.

Test and services not included in the referral or performed outside the specialist's office may require a separate authorization.

Q. Who do I contact if I have a complaint?

A. If you have an inquiry or complaint about the service you received, your coverage or a provider, you may call Customer Service at the phone number on your NHP ID Card.

Q. What if I'm still not satisfied with the resolution of the complaint?

A. If you are not satisfied with the resolution of your complaint you may file a formal written appeal within 180 days of the occurrence of the incident. Written appeals must be mailed to:

Neighborhood Health Partnership, Inc.

PO Box 5210

Kingston, NY 12402-5210

Attention: Appeal Coordinator

If you need assistance preparing your appeal, you may call Customer Service at the phone number on your NHP ID Card.

Q. How do I add my newborn baby to my coverage?

A. Please complete and return an NHP enrollment form within 60 days of your baby's date of birth, even if you already have family coverage. You may obtain enrollment forms through your employer group through the HR department. If NHP receives your baby's enrollment form within 30 days of birth, NHP will not charge an additional premium for the first 30 days of coverage. NHP must receive your completed enrollment form within 60 days of your baby's date of birth.

Q. Does NHP have a Quality Improvement program?

A. To request a summary of the NHP Quality Improvement program's progress and achievements, you may call Customer Service at the phone numbers on your NHP ID card, Monday through Friday between 8:00 am and 6:00 pm. For the hearing impaired (TTY), call the National Relay Center at 1-800-828-1120.

Q. What drugs generally are not covered?

A. In general, the following categories of drugs are either excluded, or have limitations:

- Appetite suppressants
- Erectile dysfunction drugs
- Infertility drugs
- Drugs used for cosmetic purposes
- Smoking cessation products
- Some injectables

Q. How do I get care after my doctor's office hours?

A. If it is not an emergency, you may call your doctor's office and work with his/her answering service to put you in contact with your doctor. If you are sick or injured, it can be difficult to make health care decisions. You may not know if you should go to the emergency room, visit an urgent care center, make a doctor's appointment or use self-care. Nurseline Services can provide you information, support, and education for any health-related question or concern. An experienced Nurseline nurse can give you information to help you decide. You can call the 1-866-780-9857 Nurseline toll free number anytime.

If you have an emergency, go to the nearest emergency room. If you need urgent care services (minor injuries or illnesses that require immediate attention, but are not severe enough to go to the emergency room), go to one of the urgent care centers in NHP's network. If you are

not sure you are experiencing an emergency, go to the nearest emergency room or call 911.

Q. Does NHP have a Utilization Management program?

A. NHP has a Utilization Management (UM) program to ensure that utilization decisions affecting the members' healthcare are done in a fair, impartial and consistent manner. The UM components are prior authorization, concurrent review, retrospective review and case management. The UM program is designed to make healthcare services available to members in a medically appropriate, accessible, cost-effective by evaluating service and care, and making decisions regarding benefit coverage.

The following are brief summaries of each component:

Prior authorization is the process of health services being reviewed before services are approved through the referral process.

Concurrent Review is the process of continuous medical monitoring while the member is in an inpatient facility or under a plan of care. This review assures that all the days in the facility are medically appropriate. If services are needed after discharge, NHP assists with the coordination of care in an alternative setting.

Retrospective Review is the review of care rendered to a member without providing NHP appropriate clinical data. NHP reviews clinical information obtained from the provider or facility. The review assures that services provided would have been approved as through the prior authorization process.

Case Management is the process whereby medical cases that are serious or medically complex are flagged and reviewed to assure that appropriate care is rendered to the member through a plan of treatment and the status of the member's condition is updated. Close communication with the practitioner and the member is maintained.

The NHP Medical Management staff is accessible to practitioners and members to discuss UM issues, including UM decisions and questions about the program and process.

The Medical Management staff is available during normal business days. Calls received after hours, weekends and holidays are forwarded to an after-hours line. You may also call Customer Service at the phone numbers on your NHP ID card.

Q. How can I get copies of my medical records?

A. You should request copies of your medical records from your PCP and your other providers.

Q. What are the rules for changing my PCP?

A. You may change your PCP once every month, and the change will be effective the first of the month following the request of the change.

Q. How does NHP secure the confidentiality of my Protected Health Information (PHI)?

A. NHP takes many steps to ensure that your Protected Health Information (PHI) remains confidential. Our routine notifications of our privacy practices includes: our commitment to your privacy; how NHP uses and discloses your PHI; other uses and disclosures permitted or required by law; your rights regarding your PHI; how to obtain further information; and how to file a complaint. NHP must ask for your authorization before disclosing your PHI for non-routine purposes. NHP also allows you access to your PHI upon written request.

Employees of NHP receive education and training to ensure that your written, oral and electronic PHI is kept confidential. PHI transmitted electronically is encrypted and any documents containing your PHI are stored in a secure area with access limited to designated individuals. NHP uses, discloses and requests only the minimum amount of information necessary. NHP does not disclose PHI to

your employer for employment-related purposes without your authorization, but may disclose PHI for plan administrative purposes. To obtain a complete Privacy Notice outlining all of NHP's privacy practices, call Customer Service at the phone numbers on your NHP ID card or at www.myNHP.com.

Q. How does NHP evaluate new technology for inclusion as a covered benefit?

A. UnitedHealthcare's Medical Technology Assessment Committee evaluates the strength of clinical evidence supporting the use of new and existing health services. Conclusions of this committee help to determine whether new technology and health services will be covered.

ARTICLE I - DEFINITIONS

For purposes of the Handbook, the following terms will have the following meanings:

ADOPTED CHILD means a child who is adopted by the Subscriber in accordance with Chapter 63, Florida Statutes or the applicable laws of the state where the adoption was finalized.

ADVERSE DETERMINATION means a coverage determination by NHP that an admission, availability of care, continued stay, or other healthcare service or healthcare supply has been reviewed and, based upon the information provided, does not meet NHP's requirements for Medical Necessity, appropriateness, healthcare setting, level of care or effectiveness, and coverage for the requested service is therefore denied, reduced, or terminated.

APPEALS means a written Complaint submitted by or on behalf of a Member to NHP regarding:

1. availability, coverage for the delivery, or quality of healthcare services, including a Complaint regarding an Adverse Determination made pursuant to utilization review;
2. claims payment, handling, or reimbursement for healthcare services; or
3. matters pertaining to the contractual relationship between a Member and NHP.

Only those providers who have been directly involved in the treatment or diagnosis of the Member relating to the Appeal may submit an appeal on behalf of a Member.

APPLIED BEHAVIORAL ANALYSIS - the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement and functional analysis of the relations between environment and behavior.

AUTISM SPECTRUM DISORDER - any of the following disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association:

1. Autistic disorder,
2. Asperger's syndrome,
3. Down syndrome,
4. Pervasive developmental disorder not otherwise specified.

COMPLAINT means any expression of dissatisfaction by a Member, including dissatisfaction with the administration, claims practices, or provisions of services, which relate to the quality of care provided by a provider. Members may submit a Complaint to NHP or to a State Agency. A complaint is part of the informal steps of an appeal procedure and is not part of the formal steps of an appeal procedure unless it is an Appeal as defined in this Article.

COPAYMENT means a specified dollar amount which the Member must pay directly to the Network Provider for specified Covered Services at the time services are rendered. Copayment amounts are set forth in the Summary of Benefits and are subject to Out-of-Pocket Maximum established by NHP.

COVERED SERVICES means those Medically Necessary services and supplies described in this Handbook that are not otherwise excluded or limited. To be a Covered Service, a service must be provided by a Network Provider in accordance with NHP's referral and approval procedures described in this Handbook, except in the case of an Emergency Medical Condition or as otherwise expressly stated in Article V. Services provided by a Non-Network Provider are not Covered Services unless receipt of services from such provider was approved in advance by NHP or in the case of an Emergency Medical Condition.

CUSTODIAL CARE means care that serves to assist an individual for the purpose of meeting personal needs and which could be provided by persons without professional skills or training. Custodial Care includes assistance with the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, and using the toilet, preparation of special diets, and supervision of medication that usually can be self-administered. In determining whether a person is receiving Custodial Care, consideration is

given to the level of care and medical supervision required and furnished. A determination that care received is custodial is not based on the patient's diagnosis, type of condition, degree of functional limitation, or rehabilitation potential.

DOMESTIC PARTNER - a person of the opposite or same sex with whom the Subscriber has established a Domestic Partnership.

All of the following requirements apply to both persons:

- They must not be related by blood or a degree of closeness that would prohibit marriage in the law of the state in which they reside.
- They must not be currently married to, or a Domestic Partner of, another person under either statutory or common law.
- They must share the same permanent residence and the common necessities of life.
- They must be at least 18 years of age.
- They must be mentally competent to consent to contract.

ELIGIBLE DEPENDENT or DEPENDENT - the Subscriber's legal spouse or a child of the Subscriber or the Subscriber's spouse. All references to the spouse of a Subscriber shall include a Domestic Partner. The term child includes any of the following:

- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed for adoption.
- A child placed for foster care.
- A child for whom legal guardianship has been awarded to the Subscriber or the Subscriber's spouse.
- A newborn child of an Enrolled Dependent. The newborn child may be covered from birth to 18 months of age.

The definition of Dependent also includes parents and grandparents or such other sponsored Dependents as agreed upon by us and the Group.

To be eligible for coverage, a Dependent must reside within the United States.

The definition of Dependent is subject to the following conditions and limitations:

- A Dependent is a child under 26 years of age.
- A Dependent includes a dependent child age 26 or older who is or becomes disabled and dependent upon the Subscriber.

In the event the Subscriber has a Dependent who meets the following requirements, extended coverage is available for that Dependent up to the age of 30. Contact your Group for details. To be eligible for extended coverage, a Dependent must satisfy the following:

- Does not have dependent of his or her own;
- Is a resident of Florida or a Student, and
- Does not have coverage as a named subscriber, insured, enrollee or covered person under any other group, blanket or franchise health insurance policy or individual health benefits plan, or is not entitled to benefits under Title XVIII of the Social Security Act.

If such a Dependent's coverage is terminated at the end of the month in which the Dependent reached age 26, the child is not eligible to be covered unless the Dependent was continuously covered by Creditable Coverage without a gap in coverage of more than 63 days.

A child who is covered under extended coverage provisions set forth above ceases to be eligible as a Dependent on the last day of the year following the child's attainment of the limiting age or when the child no longer meets the requirements.

The Subscriber must reimburse us for any Benefits that we pay for a child at a time when the child did not satisfy these conditions.

A Dependent also includes a child for whom health care coverage is required through a *Qualified Medical Child Support Order* or other court or administrative order. The Group is

responsible for determining if an order meets the criteria of a *Qualified Medical Child Support Order*.

A Dependent does not include anyone who is also enrolled as a Subscriber. No one can be a Dependent of more than one Subscriber.

ELIGIBLE EMPLOYEE means a person employed with the Group who works or resides in the Service Area and is eligible to enroll as a Subscriber. An individual is considered to work within the Service Area when the physical location from which he/she performs substantially all of his/her work-related activities is physically located within the Service Area.

Note: If an Eligible Employee is currently residing in a continuing care facility or a retirement facility consisting of a nursing home or assisted living facility and residential apartments, this notice applies to that person. You may request to be referred to that facility's skilled nursing unit or assisted living facility.

An Eligible Employee does not include any person:

- who spends more than 90 days (consecutive or non-consecutive) in any year outside the United States for any reason;
- who is a seasonal or temporary employee;
- who no longer works or resides in the Service Area; or
- who is unable to receive routine care within the Service Area due to any reason.

ELIGIBLE EXPENSES means the amount NHP pays Non-Network Providers, including those who are Facility-based Physicians or providers. They will be reimbursed as follows:

For Covered Services provided by a Network Provider, Members are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Covered Services provided by a Non-Network Provider (including Emergency Health Services or services otherwise arranged by NHP), the Member will not be responsible to the Non-Network Provider for any amount billed that is greater than the amount NHP determines to be an Eligible Expense as described below. Eligible Expenses are determined solely in accordance with NHP's reimbursement policy guidelines, as described in this Agreement.

Eligible Expenses are based on the following:

- When Covered Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Services are received from a Non-Network Provider as a result of an Emergency or as otherwise arranged by us, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by state law.
- For Covered Services received on a non-Emergency basis at a Network Hospital from a non Network Emergency care Physician, radiologist, anesthesiologist, pathologist, consulting Physician, neonatologist, intensivist, assistant surgeon and surgical assistant or at a Network clinic or Physician office by a non-Network Emergency care Physician, radiologist, anesthesiologist or pathologist, the Eligible Expense is based on 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for the same or similar service within the geographic market.

When a rate is not published by CMS for the service, we use a gap methodology that uses a relative value scale, which is usually based on the difficulty, time, work, risk and resources of the service. The relative value scale currently used is created by Ingenix, Inc. If the Ingenix, Inc. relative value scale becomes no longer available, a comparable scale will be used. We and Ingenix, Inc. are related companies through common ownership by UnitedHealth Group.

When a rate is not published by CMS for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under CMS published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

- For Emergency Health Services delivered by a Non-Network Provider, the Eligible Expense is based on the higher of:

- The median amount negotiated with Network Providers for the same service
- The amount calculated pursuant to Florida state statute 641.513
- 100% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for the same or similar service in the locality in which the service was provided.

EMERGENCY MEDICAL CONDITION means:

1. A medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain or other acute symptoms, such that the absence of medical attention could reasonably be expected to result in any of the following:
   a. serious jeopardy to the health of a patient, including a pregnant woman or fetus;
   b. serious impairment of bodily functions;
   c. serious dysfunction of any bodily organ or part.
2. With respect to a pregnant woman, an emergency Medical Condition also means:
   a. that there is inadequate time to affect safe transfer to a Network Hospital prior to delivery:
   b. that such a transfer may pose a threat to the health and safety of the patient or fetus; or
   c. that there is evidence of the onset and persistence of uterine contractions or rupture of the membranes.

EMERGENCY SERVICES AND CARE means medical screening, examination, and evaluation by a Physician or, to the extent permitted by applicable law, other appropriate personnel under the supervision of a Physician, to determine if any Emergency Medical Condition exists and, if it does, the care, treatment, or surgery for a Covered Service by a Physician necessary to relieve the Emergency Medical Condition, within the service capability of a Hospital.

ENROLLED DEPENDENT means an Eligible Dependent who is properly enrolled for coverage under the Agreement.

ENROLLMENT DATE means the date of enrollment of the individual covered under the Agreement.

ENROLLMENT FORM means the enrollment application completed and signed by the Subscriber providing necessary information for NHP, listing all Eligible Dependents who are to become Members on the Individual Effective Date, and showing the Members' choices of Primary Care Physicians.

EXPERIMENTAL OR INVESTIGATIONAL SERVICE(S) - medical, surgical, diagnostic, psychiatric, mental health, substance use disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time we make a determination regarding coverage in a particular case, are determined to be any of the following:

Not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not identified in the *American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use.

Subject to review and approval by any institutional review board for the proposed use. (Devices which are FDA approved under the Humanitarian Use Device exemption are not considered to be Experimental or Investigational.)

The subject of an ongoing clinical trial that meets the definition of a Phase II or III clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

Exceptions:

Clinical trials for which Benefits are available as described in Article III. If you are not a participant in a qualifying clinical trial, as described in Article III, and have a Sickness or condition that is likely to cause death within one year of the request for treatment we may, as we determine, consider an otherwise Experimental or Investigational Service to be a Covered

Health Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.

GENERAL PATIENT INFORMATION means routine medical, clinical and demographic information about Members. Examples of General Patient Information include, without limitation, clinical information on claims forms, any Member information loaded and maintained in computer systems, telephone logs, demographic information from Groups, medical histories, and information obtained about Members from Network Providers and Non-Network Providers.

GROUP means a Large Employer as defined in this section.

HOME HEALTH CARE means Home Health Services provided by a Home Health Care Agency for the care and treatment of the patient who is confined to home and under the direct care and supervision of a Physician.

HOME HEALTH CARE AGENCY means an organization duly licensed as a Home Health Care Agency under the laws of the state in which it is located. An agency operated by state or local government, which provides Home Health Care in the home in accordance with applicable laws, is also considered a Home Health Care Agency.

HOSPICE means an agency or organization that is licensed, accredited or approved under the laws of the jurisdiction in which services are provided, to provide counseling and medical services (and may include room and board) to a Terminally Ill person.

HOSPITAL means an institution that:

1. is licensed and operated as a hospital under the laws of the state where it is located; and

2. is accredited as a hospital by the Joint Commission on Accreditation of Healthcare Organization or by the American Osteopathic Association.

In no event will the term "Hospital" include a convalescent nursing home or any institution, or part thereof, which is used primarily as a convalescent facility, rest facility or nursing facility for the aged, an ambulatory surgery center, a facility for the care and treatment of mental disorders, alcoholism and drug dependency, or a facility which primarily provides custodial or rehabilitative care.

IDENTIFICATION CARD means the document of identification issued to Members by NHP.

ILLNESS means a physical, mental or nervous disorder, pregnancy or any condition determined by the United States Center for Disease Control (CDC) to be predictive of an immune disorder, including all related or resulting diseases and conditions.

INDIVIDUAL EFFECTIVE DATE means the first date as of which a Member is entitled to obtain Covered Services.

INITIAL ENROLLMENT PERIOD means the first 30 day period for which an individual is eligible to enroll for coverage, whether or not such individual chooses to enroll.

INJURY means an accidental bodily injury sustained by the Member that is the direct cause of the need for Covered Services. Such injury must be independent of disease, bodily infirmity or other cause.

INPATIENT or INPATIENT HOSPITAL SERVICE means admission to a Hospital for bed occupancy for the purpose of receiving Medically Necessary Inpatient Hospital Services. A Member is considered a Hospital Inpatient if formally admitted to the Hospital as an Inpatient by a Physician's order.

INTENSIVE OUTPATIENT TREATMENT means a structured outpatient mental health or substance-related and addictive disorders treatment program that may be free-standing or Hospital-based and provides services for at least three hours per day, two or more days per week.

LARGE EMPLOYER means an employer that is actively engaged in business, has its principal place of business in the state of Florida, and employs 51 or more Eligible Employees on one or more business days during the preceding year.

MEDICALLY NECESSARY means a Covered Service that NHP determines: (1) is appropriate, consistent and necessary for the symptoms, diagnosis or treatment of a medical condition; (2) is likely to result in demonstrable medical benefit; (3) is not provided primarily for the

convenience of the Member, the Member's family, attending or consulting Physician, or other healthcare provider; (4) is not custodial or supportive care or rest cures; (5) is in accordance with standards of good medical practice in the medical community; (6) is approved by the Food and Drug Administration (FDA) or the appropriate medical body or board for the condition in question; and (7) is the most appropriate, efficient and economical medical supply, service, level of care or location which can be safely provided to treat the Member. When used in relation to Hospital Inpatient Service, Medically Necessary services only include those services and supplies that cannot be safely and satisfactorily provided at home, in a physician's office, as an outpatient, or a facility of lesser intensity. Medical Necessity, when used in relation to services or supplies, will have the same meaning as Medically Necessary.

MEMBER means the Subscriber and if dependent coverage is in force, his or her Enrolled Dependents.

MENTAL AND NERVOUS DISORDERS means mental and nervous disorders as defined in the standard nomenclature of the American Psychiatric Association.

NETWORK - when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with us or with our affiliate to participate in our Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services by way of their participation in the Shared Savings Program. Our affiliates are those entities affiliated with us through common ownership or control with us or with our ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some of our products. In this case, the provider will be a Network provider for the Covered Health Services and products included in the participation agreement, and a non-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

NETWORK HOSPITAL means a Hospital that has a written contract in force with NHP to render Covered Services to Members.

NETWORK PHYSICIAN means a Physician who has a written contract in force with NHP to render Covered Services to Members.

NETWORK PHYSICIAN OFFICE(S) means the offices and clinical facilities operated by or for Network Physicians to provide Covered Services to Members under the Agreement.

NETWORK PROVIDER means Hospitals, Physicians, and other providers of healthcare goods and services who have written contracts in force with NHP to render such goods and services that they are licensed, certified or otherwise authorized by NHP to provide to Members. Network Providers may also include the following Providers licensed under Florida Statutes: psychologists licensed pursuant to Chapter 490, mental health counselors licensed pursuant to Chapter 491, marriage and family therapists licensed pursuant to Chapter 491, clinical social workers licensed pursuant to Chapter 491, optometrists licensed under Chapter 463, certified nurse anesthetists and nurse midwives licensed under Chapter 464, nurse practitioners licensed under Chapter 464, and physician assistants licensed under Chapter 458, Florida Statutes.

NETWORK SPECIALIST means a Specialist who has a written contract in force with NHP to render Covered Services to Members, and to whom a Member is referred for consultation or treatment by the Member's Primary Care Physician or NHP.

NEWBORN means the first 60 days of life from and including the date of birth.

NON-NETWORK PROVIDER means a Hospital, Physician or other provider of healthcare goods and services that is not a Network provider at the time the healthcare service or supply is provided.

OPEN ENROLLMENT PERIOD for a Large Employer means a 30-day time period immediately prior to the anniversary date of the Effective Date. During the Open Enrollment Period, Eligible Employees and Eligible Dependents who have not previously enrolled with NHP may enroll. The Open Enrollment Period occurs at least once every 12 months.

OUT OF POCKET MAXIMUM means a specified limit to the amount of Copayments for a Member or a Member's family, as listed in the Summary of Benefits.

OUTPATIENT or OUTPATIENT SERVICES means Covered Services that are not Inpatient Hospital Services. A Member is considered to be an Outpatient when he/she is a patient of an organized medical facility or distinct part of such facility and, in the judgment of NHP, is expected to receive professional services, including observation services, on an outpatient basis up to a 72-hour period, regardless of the time of admission, whether or not a bed is used.

PARTIAL HOSPITALIZATION or DAY TREATMENT means a structured ambulatory program that may be a free-standing or Hospital-based program and that provides services for at least 20 hours per week.

PHYSICIAN means an individual who is duly licensed to provide medical services by the states in which he or she is practicing and who is acting within the scope of such license. A Physician will include a doctor of medicine licensed under Chapter 458, a doctor of osteopathy licensed under Chapter 459, a doctor of podiatry licensed under Chapter 461, an ophthalmologist licensed under Chapter 458 or Chapter 459, and a chiropractic physician licensed under Chapter 460, Florida Statutes.

PHYSICIAN'S SERVICES means professional services or medical care rendered by a Physician when Medically Necessary for the diagnosis or treatment of an Illness or Injury. To the extent a Physician employs or engages a nurse practitioner or physician assistant to provide services under the Physician's supervision, directly or indirectly, these providers may provide Covered Services consistent with their scope of practice.

PLAN MEDICAL DIRECTOR means a Physician employed by NHP, or his or her appointed designee.

PRIMARY CARE PHYSICIAN is a Network Physician who has a written contract in force with NHP and is responsible for providing, prescribing, authorizing and coordinating the medical care and treatment of the Member.

PRIOR AUTHORIZATION means that NHP has determined that the admission, surgery, care, treatment or other service or supply is Medically Necessary and appropriate for the diagnosis and condition of the patient and is eligible for coverage. Prior Authorization does not, however, guarantee or confirm benefits under the Agreement. Benefits are subject to eligibility at the time charges are actually incurred and all other terms, provisions, exclusions and limitations in this Handbook. Prior Authorization decisions are decisions concerning reimbursement and do not replace nor are they intended to influence the treatment decisions of the Member's Physician.

SCHOOL means a public or private secondary school, accredited college or university, or licensed trade school.

SERVICE AREA means those counties approved under Chapter 641 Florida Statutes and enumerated on the Health Care Provider Certificate of NHP.

SHARED SAVINGS PROGRAM - the Shared Savings Program provides access to discounts from the provider's charges when services are rendered by those non-Network providers that participate in that program. We will use the Shared Savings Program to pay claims when doing so will lower Eligible Expenses. We do not credential the Shared Savings Program providers and the Shared Savings Program providers are not Network providers. Accordingly, in Benefit plans that have both Network and Non-Network levels of Benefits, Benefits for Covered Health Services provided by Shared Savings Program providers will be paid at the Non-Network Benefit level (except in situations when Benefits for Covered Health Services provided by non-Network providers are payable at Network Benefit levels, as in the case of Emergency Health Services). When we use the Shared Savings Program to pay a claim, patient responsibility is limited to Coinsurance calculated on the contracted rate paid to the provider, in addition to any required deductible.

SKILLED NURSING FACILITY means an institution that:

1. is licensed by the state laws where it is located and operated as a Skilled Nursing Facility as defined by those state laws;
2. provides skilled nursing services and is not primarily a place for rest, Custodial Care, senility care, drug addiction, alcoholism, substance use disorders, intellectual disability, psychiatric

disorders, or chronic brain syndromes, nor a nursing home or place for the aged; and

3. is accredited as a Skilled Nursing Facility by the Joint Commission on Accreditation of Healthcare Organizations, as a Certified Acute Rehabilitation Facility, or approved by Medicare.

SPECIALIST means a Physician who specializes in a particular field of medicine.

STUDENT means a person who is enrolled in and attending School. A Registrar's letter of status confirmation must be provided upon NHP's request. Student status is determined in accordance with the standards set forth by the School. A person is no longer a Student and coverage may terminate at the end of the year in which the person graduates or is otherwise no longer enrolled and in attendance at the School. A person continues to be a Student during periods of vacation as established by the School.

SUBSCRIBER means the eligible Employee who has enrolled for coverage.

TERMINALLY ILL means that the Member has a medical prognosis, as certified by a Network Physician, of a life expectancy of six months or less.

URGENT APPEAL means an appeal regarding an Adverse Determination when the standard time frame of the Appeal procedure would seriously jeopardize the life or health of a Member or would jeopardize the Member's ability to regain maximum function.

URGENT CARE SERVICES means services for an unforeseen illness, injury, or condition (not an Emergency Medical Condition) that, (i) could result in serious injury or disability unless medical attention is received or (ii) substantially restricts the member's activities.

ARTICLE II - INDIVIDUAL ENROLLMENT, EFFECTIVE DATE, TERMINATION OF COVERAGE AND CONTINUATION

A. ELIGIBLE EMPLOYEE AND DEPENDENT ENROLLMENT AND EFFECTIVE DATE

1. During the Initial Enrollment Period prior to the Individual Effective Date, in order to enroll for coverage, all Eligible Employees must accurately complete and sign an Enrollment Form listing Eligible Dependents.

2. All statements on the Enrollment Form must be accurate and complete. Providing false or misleading information or omitting required information in the enrollment process or at any other time gives rise to termination of the Eligible Employee's coverage. Please note there is a time limit on certain defenses: Regarding a misstatement in the application, after 2 years from the issue date, only fraudulent misstatements in the application may be used to void the Group Service Agreement or deny any claim for loss incurred or disability starting after the 2-year period.

3. Eligible Employees and their Eligible Dependents whose Enrollment Forms are received by NHP:

   i. within 30 days prior to or for 30 days after the date such individual first becomes eligible for coverage: or

   ii. during an Open Enrollment Period, will become effective on the Individual Effective Date, as provided in paragraph 4 below.

4. The Individual Effective Date will be the first day of the Premium Month after the date the individual first becomes eligible for coverage. Covered Services rendered to Members on or after the Individual Effective Date and prior to termination of the Members' coverage are subject to Article VI - Exclusions and Limitations and all other terms and conditions in this Handbook.

5. ***Late Enrollment***. A late enrollee may only enroll for coverage during an Open Enrollment Period.

6. ***Special Enrollment***. An individual is not a late enrollee if:

   a) the individual was covered under another employer health plan during his or her Initial Enrollment Period: and:

      i. the individual lost coverage under such plan as a result of loss of eligibility for the coverage, including legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment, or the coverage was terminated as a result of the termination of the employer contributions toward such coverage or lost eligibility under *Medicaid or Children's Health Insurance Program (CHIP)*; and

      ii. the individual requests to enroll and the Enrollment Form is submitted to NHP either within 30 days after termination of his or her prior coverage or within 60 days if prior coverage was *Medicaid or Children's Health Insurance Program (CHIP)*;

   OR

   b) the person was covered under a COBRA continuation provision or continuation of coverage pursuant to Section 627.6692, Florida Statutes, and the coverage under such provision was exhausted, and the Enrollment Form is submitted to NHP within 30 days of such exhaustion;

   OR

   c) the person becomes a dependent through marriage, birth, adoption, foster care or placement for adoption and submits an Enrollment Form to NHP within 30 days of such marriage, birth,

adoption, or placement for adoption;

OR

d) in the case of the birth or adoption of a child, the individual or spouse submits an Enrollment Form to NHP within 30 days of such birth or adoption, if such person is otherwise eligible for coverage;

OR

e) the person previously declined coverage but becomes eligible for a premium assistance subsidy under *Medicaid or Children's Health Insurance Program (CHIP)*. Coverage begins after we receive an Enrollment Form and any required premium within 60 days of the date of determination of subsidy eligibility.

7. ***Adopted Children***. All benefits applicable to children will also be payable with respect to a Subscriber's Adopted Child. Coverage for an Adopted Child begins when the child is placed in the residence of the Subscriber in compliance with Florida law, if a written agreement to adopt such child has been entered into by the Subscriber prior to the birth of the child. Coverage for a newborn Adopted Child begins at the moment of birth whether or not such contract is enforceable. However, coverage is not available for an Adopted Child if the child is not ultimately placed in the residence of the Subscriber in Compliance with Chapter 63, Florida Statutes. The Subscriber must enroll such child within 30 days of the birth or placement of the Adopted Child.

8. ***Newborn Children***. All benefits applicable for children will be payable with respect to a child born to the Subscriber or the Subscriber's Enrolled Dependents after the Individual Effective Date. Coverage for a Newborn Child will begin as of the date of birth if a completed and signed enrollment form is received by NHP within 30 days following the date of birth (the "Birth Notice Period"). If timely notice is given, NHP will not charge an additional premium for the 30-day Birth Notice Period. If the enrollment request is not received by NHP within 60 days of the birth of the child, such child will be a late enrollee and subject to the provisions of Late Enrollment described in this Article. Coverage for an enrolled Newborn Child of a Member, other than the Subscriber's spouse, will automatically terminate 18 months after the birth of such Newborn Child.

9. ***Marriage***. Upon a marriage under the laws of the state in which the marriage occurred, the spouse of a Subscriber must submit an Enrollment Form within 30 days of the marriage. If the Enrollment Form is timely submitted, the Individual Effective Date will be the date of the marriage. If the spouse is not enrolled during this period, the spouse may be enrolled during the next Open Enrollment Period.

10. ***Non-Discrimination***. NHP will not expel, refuse to renew the coverage of, or refuse to enroll any Eligible Employee or Eligible Dependents on the basis of race, color, creed, marital status, sex or national origin. Moreover, NHP will not expel or refuse to renew the coverage of a Member on the basis of such Member's age, health status, healthcare needs or expected cost of healthcare services of the Member.

B. RE-ENROLLMENT AFTER TERMINATION

A Subscriber and/or Enrolled Dependent(s) whose coverage is terminated by such Subscriber will be entitled to apply for re-enrollment only during an Open Enrollment Period.

C. TERMINATION OF COVERAGE

The coverage of any Member will terminate:

1. at the end of the Premium Month during which a Member no longer qualifies as an Eligible Employee or Eligible Dependent. The Group must notify NHP within 30 days of the date a Member no longer qualifies as an Eligible Employee or Eligible Dependent. If notice is not given to NHP within 30 days, then termination of such individual will become effective at the end of the Premium Month in which notice is received by NHP. The Group is

responsible for payment of any required Premiums until the end of the Premium Month in which notice was received. Coverage will terminate automatically and without notice.

2. at the end of the Premium Month for which the last Premium was paid in full by the Group to NHP, if the Premium was not paid by the end of any Grace Period listed in the Group Service Agreement. The Group will be responsible for providing notice to Members.

3. on the last day of the Premium Month during which NHP has terminated the Member's coverage for cause. Cause for termination will include: i) fraud or intentional misrepresentation or omission of material fact in applying for eligibility or seeking any benefits; ii) disruptive, unruly, abusive, unlawful, fraudulent or uncooperative behavior towards a healthcare provider or administrative staff that, as NHP determines, impairs NHP's ability to arrange for Covered Services; iii) failure to pay, upon notice, fees or Copayments which are the responsibility of the Member: iv) misuse of the identification Card by any person; v) a Member's refusal to follow his or her Physician's treatment plan; vi) failure to provide any signed releases, consents, assignments, or other documents and information reasonably requested by NHP; or vii) failure to cooperate with NHP in the administration of the Handbook, including failure to abide by utilization review and case management. NHP will notify the Member in writing 45 days prior to the date of termination: provided, however, when the grounds for termination are based upon fraud or intentional misrepresentations or omission of material fact or when Members may not be lawfully covered under the Agreement, coverage will be cancelable by NHP retroactive to the Individual Effective Date of the Member. NHP may recover from Member any and all amounts paid on behalf of Member for this period.

4. on the last day of the Premium Month during which the Member becomes eligible for coverage under Medicare, Title XVII1 of the Social Security Act, as amended.

No Member will have his/her coverage terminated under this provision because of the amount, variety or cost of services required by such Member.

D. EXCEPTIONS TO TERMINATION OF COVERAGE

1. NHP will not terminate a Subscriber's coverage solely due to

   a. absence from work due to Illness or Injury. In such event, the Subscriber's coverage can be continued for up to 12 months if the Group continues to make Premium payments for the Subscriber's coverage,; or

   b. absence from work due to a temporary lay-off or leave of absence approved by the Group. In such event, the Subscriber's coverage can be continued for up to 2 months, if the Group continues to make Premium payments for the Subscriber.

2. If coverage for an Enrolled Dependent child would terminate because of that child's attainment of the applicable Limiting Age but at such time, the child is incapable of self-support due to intellectual disability or physical disability and is chiefly dependent upon the Subscriber for support and maintenance, that child's coverage may be continued during such incapacity as long as:

   a. Premiums are paid for such child's coverage;

   b. the Subscriber's coverage remains in effect; and

   c. when a claim is denied due to the child's attainment of the Limiting Age, NHP is provided with required proof of such child's incapacity and dependence for support and maintenance.

3. If coverage for an Enrolled Dependent child would terminate because of that child's attainment of the applicable Limiting Age, that child's coverage may be continued to the end of the year in which the Enrolled Dependent child reaches the Limiting Age.

E. COBRA COVERAGE CONTINUATION

A Group subject to the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") (i.e. Groups with 20 or more employees) is required to provide the Member a notice of continuation of coverage rights under COBRA. The Group is responsible for meeting all of the obligations under COBRA, including, without limitation, notifying all Members of their rights under COBRA. If the Group fails to meet its obligations under COBRA, NHP will not be liable for any claims incurred by a Member following the termination of coverage.

The following is a brief summary of the Member's rights under COBRA and the general conditions necessary to qualify for such COBRA continuation benefits.

A Member may be entitled to elect continuation of coverage under COBRA in the event of the occurrence of any of the following "qualifying events" where such event results in the Member's loss of coverage under the Agreement:

1. Termination of the Subscriber's employment for any reason other than gross misconduct.
2. A reduction in the Subscriber's work hours.
3. The Subscriber's death.
4. The Subscriber's divorce or separation.
5. The Subscriber's or Enrolled Dependent's entitlement to benefits under Title XVIII of the Social Security Act ("Medicare").
6. The Subscriber's enrolled Dependent Child ceasing to be an Eligible Dependent as defined in the Agreement.

The Member must elect to continue coverage under COBRA within the election period determined by the Group. An election period must be for at least 60 days. It will begin no later than the date the Member would have otherwise lost coverage under the Agreement due to a qualifying event. A Member who elects COBRA continuation of coverage is subject to all the same terms and conditions of the Agreement as a Member who has not had a qualifying event.

Such continuation of coverage will be made available at the Premium specified in the Agreement, which will not exceed: (1) 102%; or (2) 150% for allowed extensions after the 18-month continuation period, of the total Premium charged for such period of coverage for a similarly situated Member who has not had a qualifying event. The Member must pay any required Premiums directly to the Group.

If the qualifying event is due to termination of employment or reduction of hours, the maximum COBRA continuation period is 18 months. The maximum COBRA continuation period is 29 months if disabled at time of the qualifying event or if the disability arises within the first 60 days of COBRA continuation. For all other qualifying events the maximum COBRA continuation period is 36 months.

F. EXTENSION OF BENEFITS

In the event the Agreement is terminated, coverage for benefits end as of the termination date, except as set forth below.

For any Illness or Injury that commenced while the Agreement was in force which results in the continuous total disability of the Member, there will be an extension of benefits beyond the date that coverage under the Agreement terminates for Covered Services necessary to treat the disabling condition only. A Member who is pregnant as of the termination date of the Group is also entitled to an extension of benefits for Covered Services necessary to treat the pregnancy only, so long as the pregnancy commenced while the Member was covered under the Agreement.

1. ***Due to total disability***. The extension of benefits due to total disability is limited to the first to occur of the following events: (i) the expiration of 12 months from the date of termination of the Agreement; (ii) such time as the Member is no longer totally disabled; (iii) a succeeding carrier provides replacement coverage without limitation as to the disability condition; or (iv) the maximum benefits payable under the Agreement have been paid.

   For the purposes of this section, a Member is totally disabled if the Member has a condition resulting from an Illness or Injury that prevents the Member from engaging in any employment or occupation for which the Member is or may become qualified by reason of education, training, or experience is not in

fact engaged in any employment or occupation for wage or profit; and is under the regular care of a Physician.

2. ***Due to pregnancy***. An extension of benefits due to pregnancy is limited to Covered Services relating to such pregnancy. An extension of benefits does not include coverage for services relating to the Newborn. Benefits will continue until the first to occur of the following events: (i) the end of such pregnancy; or (ii) the date the Member becomes covered under another plan and the succeeding carrier assumes liability for such pregnancy coverage.

3. ***Due to Student's leave of absence***. Coverage for an Enrolled Dependent child who is a Student at a post-secondary school and who needs a medically necessary leave of absence will be extended until the earliest of the following:

   - 12 months after the medically necessary leave of absence begins.
   - The Member is no longer totally disabled.
   - A succeeding carrier elects to provide replacement coverage without limitation as to the disability condition.
   - The maximum benefits payable under the Agreement have been paid.

   Coverage will be extended only when the Enrolled Dependent is covered under the Agreement because of Student status at a post-secondary school immediately before the medically necessary leave of absence begins and when the Enrolled Dependent's change in Student status meets all of the following requirements:

   - The Enrolled Dependent is totally disabled if the individual has a condition resulting from an illness or injury which prevents the individual from engaging in any employment or occupation for which the individual is or may become qualified by reason of education, training or experience, and the individual is under the regular care of a Physician.
   - The leave of absence from the post-secondary school is medically necessary, as determined by the Enrolled Dependent's treating Physician.
   - The medically necessary leave of absence causes the Enrolled Dependent to lose Student status for purposes of coverage under the Agreement.

   A written certification by the treating Physician is required. The certification must state that the Enrolled Dependent child is suffering from a serious Sickness or Injury and that the leave of absence is medically necessary.

   For purposes of this extended coverage provision, the term "leave of absence" includes any change in enrollment at the post-secondary school that causes the loss of Student status.

4. ***Exceptions to Extension of Benefits***. No Member is entitled to an extension of benefits, as provided in Article II the Agreement, if NHP has terminated the Agreement for any of the following reasons: (i) fraud or misrepresentation or omission of material fact in applying for coverage or any benefits under the Agreement; this only applies to misstatements in the application for a claim for loss incurred or disability starting after 2 years from the issue date; (ii) disenrollment for cause. as described in Article II of the Agreement; (iii) the Member has left the Service Area with the intent to relocate or establish a new residence outside the Service Area.

G. BENEFIT ELIGIBILITY

Prior Authorization for services by NHP does not guarantee or confirm benefits under the Agreement. Benefits are subject to eligibility at the time services are rendered and to all other terms, provisions, conditions, exclusions, and limitations of the Agreement.

ARTICLE III - HOSPITAL AND RELATED SERVICES

The following hospital and related services must be medically necessary and must be provided or arranged by the PCP and prior authorized by NHP, except in the case of an emergency medical condition. Services provided by Non-Network Providers are described in the definition of "Eligible Expenses" in Article I. Other services provided by Non-Network Providers are not covered unless prior authorization from NHP is obtained. This does not apply to services provided for an emergency medical condition. It is the member's responsibility to determine if a provider is a Network provider before services are rendered. Services that do not receive prior authorization from NHP as required and which were not referred by the member's Primary Care Physician or as specified above will be at the member's own expense. Any service, care or supplies which are not medically necessary, as determined by NHP, are not covered services.

Coverage is subject to any applicable copayment and to all terms, conditions, exclusions and limitations under the Agreement.

All benefits available under the Agreement are subject to Article VI, Exclusions and Limitations.

A. HOSPITAL SERVICES

1. Hospital Services provided on an inpatient or outpatient basis may include the following:
    a. semi-private room and board:
    b. use of specialized units within the facility to include operating, recovery, delivery rooms, intensive care and nursery;
    c. anesthesia services, administration and supplies;
    d. laboratory services;
    e. diagnostic services, including x-rays, nuclear medicine, sonography, and magnetic resonance imaging;
    f. medical and surgical services and supplies including medications, intravenous therapy, radiation therapy, supplies and dressings, and blood and blood products when participation in a blood replacement program is not available and administration by the Hospital;
    g. rehabilitation and therapeutic services (including physical therapy as described in Article III), respiratory therapy, cardiac therapy, occupational therapy and speech therapy. in connection with a Covered Service; and
    h. nursing care provided by hospital staff.
2. Hospital Services must be provided by a Network Hospital, unless otherwise approved in advance by NHP, or when Emergency Services or Care is necessary.

B. CLINICAL TRIALS

Routine patient care costs incurred during participation in a qualifying clinical trial for the treatment of:

- Cancer or other life-threatening disease or condition. For purposes of this benefit, a life-threatening disease or condition is one from which the likelihood of death is probable unless the course of the disease or condition is interrupted.
- Cardiovascular disease (cardiac/stroke) which is not life threatening, for which, as we determine, a clinical trial meets the qualifying clinical trial criteria stated below.
- Surgical musculoskeletal disorders of the spine, hip and knees, which are not life threatening, for which, as we determine, a clinical trial meets the qualifying clinical trial criteria stated below.

Covered Services include the reasonable and necessary items and services used to prevent, diagnose and treat complications arising from participation in a qualifying clinical trial.

Covered Services are available only when the Member is clinically eligible for participation in the qualifying clinical trial as defined by the researcher.

Routine patient care costs for qualifying clinical trials include:

- Covered Services that are typically provided absent a clinical trial.
- Covered Services required solely for the provision of the Investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications.
- Covered Services needed for reasonable and necessary care arising from the provision of an Investigational item or service.

Routine costs for clinical trials do not include:

- The Experimental or Investigational Service or item. The only exceptions to this are:
  - Certain *Category B* devices.
  - Certain promising interventions for patients with terminal illnesses.
  - Other items and services that meet specified criteria in accordance with our medical and drug policies.
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.
- Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

With respect to cancer or other life-threatening diseases or conditions, a qualifying clinical trial is a Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition and which meets any of the following criteria in the bulleted list below.

With respect to cardiovascular disease or musculoskeletal disorders of the spine, and hip and knees which are not life-threatening, a qualifying clinical trial is a Phase I, Phase II, or Phase III clinical trial that is conducted in relation to the detection or treatment of such non-life-threatening disease or disorder and which meets any of the following criteria in the bulleted list below.

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - *National Institutes of Health (NIH)*. (Includes *National Cancer Institute (NCI)*.)
  - *Centers for Disease Control and Prevention (CDC)*.
  - *Agency for Healthcare Research and Quality (AHRQ)*.
  - *Centers for Medicare and Medicaid Services (CMS)*.
  - A cooperative group or center of any of the entities described above or the *Department of Defense (DOD)* or the *Veterans Administration (VA)*.
  - A qualified non-governmental research entity identified in the guidelines issued by the *National Institutes of Health* for center support grants.
  - The *Department of Veterans Affairs*, the *Department of Defense* or the *Department of Energy* as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the *Secretary of Health and Human Services* to meet both of the following criteria:
    - Comparable to the system of peer review of studies and investigations used by the *National Institutes of Health*.

- Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

- The study or investigation is conducted under an investigational new drug application reviewed by the *U.S. Food and Drug Administration*.
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.
- The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (*IRBs*) before participants are enrolled in the trial. We may, at any time, request documentation about the trial.
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Agreement.

C. HOME HEALTH SERVICES

Home Health Services include:

1. part-time or intermittent skilled nursing services provided by a registered nurse (R.N.) or licensed practical nurse (L.P.N.);
2. part-time or intermittent home health aide services provided by a certified home health aide in the home under the supervision of a registered nurse (R.N.) or a physical, speech, or occupational therapist;
3. physical, occupational, or speech therapy: and
4. medical supplies, drugs, medicines and related pharmaceutical and laboratory services that are prescribed by a Physician and provided in connection with covered Home Health Services. Drugs or nutrients taken by mouth or self-administered by injection are not covered.

The Agreement covers all Home Health Services combined, including the services of social workers and dieticians when the Member is confined to home and requires skilled nursing services. See your Summary of Benefits for limits. All Home Health Services must be performed by a Network Home Healthcare Agency. Benefits are only available for Members confined to their homes for conditions which, in the opinion of the Network Physician, can be satisfactorily treated on such basis. A Home Healthcare treatment plan must be established in writing and approved by NHP. No Home Health Services will be provided under the Agreement beyond the date upon which, in the opinion of a Network Physician and NHP, continued Home Health Services are no longer Medically Necessary. For purposes of determining this benefit, all or part of one hour will equal one Home Healthcare visit. Services or training for activities of daily living, domiciliary care, Custodial Care or care provided for the Member's convenience are not covered. Medical supplies, drugs, medicines and related pharmaceutical and laboratory, services provided by the Network Home Healthcare Agency will not be covered as Home Health Services. The Home Health Services benefit does not provide coverage for Home Infusion Therapy as described below.

D. HOME INFUSION THERAPY

Home Infusion Therapy is the administration of drugs or nutrients using specialized delivery systems in Member's home by a Network Home Care Provider which otherwise would have required the Member's hospitalization. Drugs, medical supplies and related pharmaceutical supplies for the home infusion are covered. Drugs or nutrients taken by mouth or self-administered injectables are not covered.

E. HOSPICE CARE

The Agreement covers inpatient and/or outpatient Hospice Care for a Terminally Ill Member when requested by a Network Physician. Hospice Care is palliative care (pain control and symptom relief), rather than curative care. Hospice Care must be provided by a Network Provider. See your Summary of Benefits for limits.

F. HOSPITALIZATION AND ANESTHESIA FOR DENTAL TREATMENT

Hospitalization and general anesthesia in the delivery of Necessary dental treatment or surgery are covered only under the following conditions: 1) a Member under 8 years of age

who is determined by a licensed dentist and the Member's Primary Care Provider to need Necessary dental treatment or surgery in a Hospital or ambulatory surgical center due to a significantly complex dental condition or developmental disability in which patient management in the dental office has proved to be ineffective; or 2) whose medical condition(s) would create significant or undue medical risks if Necessary dental treatment or surgery is not rendered in a Hospital or ambulatory surgical center. Dental care, treatment or surgery is excluded from coverage.

For purposes of this benefit, "Necessary" means the necessary dental surgery or treatment where the dental condition would likely result in a medical condition if left untreated.

G. MENTAL HEALTH AND NERVOUS DISORDERS

The Agreement covers the treatment of Mental Health and Nervous Disorders. Benefits include mental health evaluations and assessment, diagnosis, treatment planning, referral services, medication management, inpatient, partial hospitalization/day treatment, intensive outpatient treatment, services at a residential treatment facility, individual, family and group therapeutic services and crisis intervention.

Depending on where the Covered Services are provided, Benefits for outpatient Mental Health and Nervous Disorders will be the same as those stated under Physician Services. Benefits for inpatient/intermediate Mental Health and Nervous Disorders will be the same as those stated under Hospital Services.

H. NEUROBIOLOGICAL DISORDERS - AUTISM SPECTRUM DISORDER SERVICES

Psychiatric services for Autism Spectrum Disorders that are both of the following:

- Provided by or under the direction of an experienced psychiatrist and/or an experienced licensed psychiatric provider.
- Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property, and impairment in daily functioning.

This section describes only the psychiatric component of treatment for Autism Spectrum Disorders. Medical treatment of Autism Spectrum Disorders is a Covered service for which Benefits are available as required by Florida law for Autism Spectrum Disorder.

Benefits include the following services provided on either an outpatient or inpatient basis:

- Diagnostic evaluations and assessment.
- Treatment planning.
- Referral services.
- Habilitative services.
- Medication management.
- Individual, family, therapeutic group and provider-based case management services.
- Crisis intervention.
- Intensive behavioral therapy.

Benefits include the following services provided on an inpatient basis:

- Partial Hospitalization/Day Treatment.
- Services at a Residential Treatment Facility.

Benefits include services provided on an outpatient basis for Intensive Outpatient Treatment.

The Mental Health/Substance Use Disorder Designee determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis. We encourage you to contact the Mental Health/Substance Use Disorder Designee for referrals to providers and coordination of care.

I. OUTPATIENT SURGERY SERVICES

Outpatient surgery services are covered services when provided by a Network Provider (i.e. an outpatient department of a Network Hospital or a Network free standing ambulatory surgery center). If Member has Outpatient Surgery Services, Member's coverage is the same as would be provided if Member was an inpatient, except semi-private room and Inpatient rehabilitation services are not covered.

J. PHYSICAL REHABILITATION

The Agreement covers Physical Rehabilitation services during a hospital stay, portion of a hospital stay, a Skilled Nursing Facility stay, or a portion of a Skilled Nursing Facility stay which is primarily for restorative physical therapy. Such services must be provided by a Network Provider, unless otherwise approved in advance by NHP.

The services must be for restorative physical rehabilitation for a condition which is subject to significant clinical improvement through relatively short term therapy, as determined by Member's Network Provider. More extensive specialized physical medicine and inpatient rehabilitation services, including physical therapy and physical rehabilitation, may be covered, subject to Medically Necessity review by NHP.

Any limits for physical rehabilitation are included in and part of the limits applicable to Skilled Nursing Facility Services, described in Article III. See your Summary of Benefits for any applicable limits.

K. SKILLED NURSING SERVICES

Includes services provided in a Skilled Nursing Facility that meet all of the following conditions:

1. ordered by and under the supervision of a Network Physician;
2. sufficiently medically complex to require supervision, assessment, planning, or intervention by a Registered Nurse (R.N.);
3. required to be performed by, or under the direct supervision, of a Registered Nurse for safe and effective performance;
4. required on a daily basis;
5. Medically Necessary to treat the Injury or Illness; and
6. consistent with the nature and severity of the Member's condition.

L. SUBSTANCE USE DISORDER SERVICES

Include those received on an inpatient or Intermediate Care basis in a Hospital or an Alternate Facility, and those received on an outpatient basis in a provider's office or at an Alternate Facility.

Benefits for Substance Use Disorder Services include:

- Substance Use Disorder and chemical dependency evaluations and assessment.
- Diagnosis.
- Treatment planning.
- Detoxification (sub-acute/non-medical).
- Inpatient.
  - Partial Hospitalization/Day Treatment.
  - Intensive Outpatient Treatment.
  - Services at a Residential Treatment Facility.
  - Referral services.
  - Medication management.
  - Individual, family and group therapeutic services.
  - Crisis intervention.

Depending on where the services are provided, Benefits for outpatient Substance Use Disorders will be the same as those stated under Physician Services. Benefits for inpatient/intermediate Substance Use Disorders will be the same as those stated under Hospital Services.

M. TRANSPLANT SERVICES

For the purposes of this section, "Transplant Services", including Bone Marrow Transplants, mean pre-transplant (i.e. evaluation), transplant and post-transplant services, and treatment of complications resulting from the transplantation. A Bone Marrow Transplant is the administration of human precursor cells to a patient to restore normal hematological and immunological functions following ablative therapy with curative intent. Bone Marrow Transplant includes ablative and non-ablative therapy with curative or life-prolonging intent. Human blood precursor cells may be obtained from the patient in an autologous transplant or from a medically acceptable related or unrelated donor, and may be derived from bone marrow, circulating blood or a combination of bone marrow and circulating blood, if chemotherapy is an integral part of the treatment involving bone marrow transplantation, the term "bone marrow transplant" includes both the transplantation and the chemotherapy.

Transplant Services are Covered Services only if NHP has separately approved the evaluation, transplant and post-transplant services. The Member or the Member's Primary Care Physician must notify NHP in advance of the Member's initial evaluation for the transplant procedure. Such notice must be sufficient to allow NHP a reasonable amount of time to determine if the transplant evaluation services are Covered Services under the Agreement. For approval of the transplant itself, NHP must be given a reasonable period of time and the opportunity to review the clinical results of the evaluation. If approval is not given, coverage will not be provided for the transplant procedure. The Agreement will not cover Transplant Services pursuant to this section if they are determined to be Experimental/Investigational by the American Medical Association DATA panel, UHC Medical Technology Assessment, any department or agency of the federal government authorized to make such determinations, or otherwise deemed not Medically Necessary by NHP. Post-transplant services and complications resulting from the transplantation are not covered if the transplant procedure was not a Covered Service.

If the transplant procedure is approved, NHP will advise the Member's Physician of those facilities that are approved for the type of transplant procedure involved. A facility must meet criteria established by the National Institute of Heart, Blood and Lung or the National Institutes of Health to be approved by NHP Coverage is available only if the pre-transplant services, the transplant procedure, and post transplant services are performed in approved facilities.

Subject to applicable conditions, exclusions and limitations of the Agreement, only the following services are covered for approved transplant procedures and related complications in approved facilities:

1. Hospital Services and Physician Services under the same terms and conditions as provided for the care and treatment of any other covered Injury or Illness under the Agreement.

2. Medical costs associated with organ acquisition and donor cost. However: (1) medical donor costs are not covered if payable, in whole or in part, by any other group plan, insurance company, organization, or person other than the donor's family or estate: (2) Non-medical organ acquisition costs and donor costs are not covered under the Agreement, unless otherwise specified: and (3) the Agreement will not cover any donor costs related to the removal of an organ from a Member for the purposes of transplantation into a recipient who is not a Member. Notwithstanding the above, donor costs associated with Bone Marrow Transplants are covered to the same extent as such services are covered for the Member receiving the Bone Marrow Transplant from the donor.

3. Transportation and lodging costs are only covered when the transplant procedure is performed in a facility which is outside the Service Area. Coverage for transportation and lodging costs are limited to any overall dollar maximum of $5,000 per transplant. This includes any related complications and follow-up visits. Transportation and lodging benefits only include: 1) round-trip coach class air fare for the Member receiving Transplant Services and one family member; and 2) lodging expenses for the Member who is the transplant recipient up to $65 per day. In the event the Member is the recipient of a bone marrow transplant, transportation and lodging cost include: 1) round trip coach class air fare for the bone marrow donor and one family member, and 2) lodging expenses for a bone marrow donor, up to the current daily limit. The Member is required to provide detailed invoices and receipts documenting such expenses to NHP in order to obtain reimbursement.

4. Bone Marrow Transplants that are specifically listed in Chapter IOD-127.001 of the Florida Administrative Code. This includes coverage for the bone marrow donor as described in items 1-3 above. Coverage for the costs for a bone marrow donor search is limited to costs associated with searches relating to immediate family members and the National Bone Marrow Donor Program.

ARTICLE IV - MEDICAL, SURGICAL AND RELATED SERVICES

The following hospital and related services must be medically necessary and must be provided or arranged by the primary care physician and prior authorized by NHP, except in the case of an emergency medical condition. Services provided by Non-Network Providers are described in the definition of "Eligible Expenses" in Article I. Other services provided by Non-Network Providers are not covered unless prior authorization from NHP is obtained. This does not apply to services provided for an emergency medical condition. It is the member's responsibility to determine if a provider is a Network provider. If you have a Point of Service plan, it is your responsibility to insure that NHP's prior authorization is obtained before services are rendered. Services that do not receive prior authorization from NHP as required and which were not referred by the member's primary care physician or as specified above will be at the member's own expense. Any service, care or supplies which are not medically necessary, as determined by NHP, are not covered services.

Coverage is subject to any applicable copayment and all terms, conditions and exclusions under the Agreement.

All benefits provided under the Agreement are subject to Article VI, Exclusions and Limitations.

Every Member must select a Primary Care Physician who is a Network Physician. Network Physicians, including Primary Care Physicians, are listed in the Network Provider Directory which is updated from time to time by NHP. If the Member fails to select a Primary Care Physician, NHP will assign one to the Member. Specialists must be selected from those Network Specialists listed in the Network Provider Director). A referral from the Primary Care Physician must be obtained before services are rendered by a Network Specialist, except as set forth below.

Except when Emergency Services and Care are required, services of Non-Network Providers are covered only when Prior Authorization is received from NHP. **It is the member's responsibility to determine if a Provider is a Network Provider and whether Prior Authorization was obtained for use of a Non-Network Provider. Non-Network Provider services that do not receive Prior Authorization from NHP and Network Provider services which were not referred by the Member's Primary Care Physician will be at the Member's own expense.** The Member may, however, receive services from a Network Chiropractor, Network Podiatrist, Network Dermatologist and any Physician who specializes in gynecology or obstetrics without a PCP referral, subject to the terms and conditions stated in the Agreement.

On or after the Individual Effective Date, a Member is entitled to the following services and care for the diagnosis or treatment of an Illness or Injury:

A. PHYSICIAN'S SERVICES

1. Consultation, examination and treatment by a Network Physician at the Hospital or Skilled Nursing Facility where the Member is confined, or at the Network Physician's Office.

2. Periodic health assessment, to include well-child care from birth, adult health examinations and immunizations, medical history, physical examination, laboratory, x-ray and other screening or diagnostic tests as indicated by the age, sex, medical history or physical examination of the Member ordered by a Network Physician in accordance with NHP's Preventive Healthcare Guidelines (which are provided to Members by NHP). Travel vaccines and immunizations are not covered.

3. A female Member may choose a Network Physician who specializes in obstetrics or gynecology as her PCP. An annual gynecological exam including manual breast exam, pelvic exam and Pap smear ("well woman exam") is covered. Medically Necessary follow-up care for conditions detected during the well woman exam may be obtained from the same Network gynecologist. Referrals to a Network Physician who specializes in obstetrics or gynecology are not required.

4. Preventive care services provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under applicable law:

   - Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*.
   - Immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention*.
   - With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
   - With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.

5. Pregnancy will be treated the same as any other condition.

6. Allergy testing and desensitization therapy to alleviate allergies, including the cost of hyposensitivity serum.

7. Benefits for treatment and services of Emergency medical conditions received from Non-Network Providers will be paid in accordance with the definition of "Eligible Expenses" in Article I. All claims and supporting documentation must be submitted to NHP in English.

B. SURGICAL SERVICES

Surgical services, including preoperative care, postoperative care and the administration of anesthesia. Services of physician operative assistants are covered according to NHP's coverage criteria for surgical assistants.

C. AMBULANCE SERVICES

Emergency ambulance services are covered. Non-emergency ambulance services required to transfer Member from a non-Network facility to the nearest Network Hospital are covered. Non-emergency ambulance services require prior authorization by NHP. Prior authorization is not required when NHP authorizes a transfer to a Network facility.

D. ANESTHESIA

Administration of anesthesia in connection with surgery or maternity care covered under the Agreement if in NHP's judgment, the nature of the procedure requires anesthesia.

E. AUTISM SPECTRUM DISORDER

Benefits are provided for Covered Health Services for Enrolled Dependents under 18 years of age or an Enrolled Dependent 18 years or older who is in high school who was diagnosed at 8 years of age or younger with Autism Spectrum Disorder. Benefits are provided for the generally recognized services listed below when provided under a treatment plan prescribed by the treating Physician.

1. Well-baby and well-child screening for diagnosing the presence of Autism Spectrum Disorder.

2. Applied Behavioral Analysis when provided by an individual certified pursuant to s. 393.17 or an individual licensed under chapter 490 or chapter 491.

3. Speech therapy.

4. Occupational therapy.

5. Physical therapy.

Coverage is subject to limits specified in your Summary of Benefits.

Note: These Benefits are in addition to any Benefits under Neurobiological Disorders - Autism Spectrum Disorders Services. Also any visit limits for Outpatient Rehabilitation and Therapies do not apply to Autism Spectrum Disorder.

F. BLOOD

Blood and blood derivatives, including administration fees, excluding blood provided through a replacement program.

G. BONES OR JOINTS OF THE JAW AND FACIAL REGION

Benefits are provided for diagnostic and surgical procedures involving bones or joints of the jaw and facial region to treat conditions caused by congenital or developmental deformity, Sickness or Injury.

Please note that Benefits are not available for care or treatment of the teeth or gums, intraoral prosthetic devices or surgical procedures for cosmetic purposes. This Benefit includes evaluation and treatment of temporomandibular joint syndrome (TMJ) when related to congenital, developmental deformity, injury or disease.

H. BREAST PUMPS

Benefits include the cost of renting one breast pump per Pregnancy in conjunction with childbirth. If more than one breast pump can meet your needs, Benefits are available only for the most cost effective pump. We will determine the following:

- Which pump is the most cost effective.
- Whether the pump should be purchased or rented.
- Duration of a rental.
- Timing of an acquisition.

I. CHIROPRACTIC SERVICES

Chiropractic Services performed by a Network Chiropractor for conditions that are medically recognized and accepted as being appropriately treated by such therapy. In addition, a Member may receive services from a Network Chiropractor without a referral from a Primary Care Provider. Refer to your Summary of Benefits for any specific limits per calendar year.

J. CLEFT-LIP/CLEFT-PALATE

Treatment and services for cleft-lip and cleft-palate for Members under the age of 18 years. Benefits for cleft-lip or cleft-palate are subject to the same terms, conditions, and limitations as all other Covered Services under the Agreement.

K. DERMATOLOGY

A Member may receive the first 5 visits per calendar year from a Network Dermatologist for office visits and for the provision of minor procedures only, without a referral from the Primary Care Physician. All other services must be upon the referral of the Primary Care Physician and receive Prior Authorization from NHP. Dermatological procedures which are primarily cosmetic in nature are not covered.

L. DIABETES

Equipment, supplies, and services including outpatient self-management training and educational services used to treat diabetes obtained from a Network Provider. Diabetes outpatient self-management training and educational services must be provided under the direct supervision of a Network diabetes educator or Network endocrinologist. Nutrition counseling must be provided by a licensed Network dietician. Coverage for insulin pumps is limited to the most cost effective pump which meets the Member's medical needs, as determined by NHP. Equipment and supplies, including insulin pumps and pump supplies, are not subject to the DME maximum set forth in Subsection L. Request for replacement pumps will be subject to medical necessity review. Routine upgrades and replacements may not be considered medically necessary.

M. DIALYSIS

Treatment and services for renal disease, including equipment, training and supplies required for effective dialysis obtained from a Network Provider.

N. DURABLE MEDICAL EQUIPMENT (DME) and DISPOSABLE MEDICAL SUPPLIES

Durable medical equipment is covered when provided in connection with or as the result of a Covered Service. Disposable medical supplies necessary for use in connection with covered DME are covered. All DME and disposable medical supplies must provide medical and therapeutic service and must be provided by a designated Network Provider. Repair or replacement of damaged equipment and the purchase or rental of duplicate equipment is not covered under the Agreement. DME is defined as equipment that meets all the following criteria:

1. Can stand repeated use.

2. Primarily and customarily used to serve a medical purpose rather than being primarily for comfort or convenience.

3. Usually not useful to a person in the absence of sickness or Injury.

4. Appropriate for home use.

5. Related to the patient's physical disorder.

6. Certified in writing by a Network Physician as Medically Necessary.

Benefits for DME and disposable medical supplies are subject to the limits on your Summary of Benefits. NHP may, at its option, authorize the purchase of DME if the rental price is projected to exceed the purchase price of the equipment.

O. ENTERAL FORMULA

The Agreement covers enteral formulas for home use which are prescribed by your Physician as medically necessary for the treatment of inherited diseases of amino acid, organic acid, carbohydrate, or fat metabolism as well as malabsorption originating from congenital defects present at birth or acquired during the neonatal period. Coverage for inherited diseases of amino acids and organic acids shall include food products modified to be low protein, for individuals, through the age of 24.

P. EYE EXAMINATIONS

Benefits include eye examinations for diseases of the eye. Initial glasses or contact lenses following cataract surgery are covered. Physician services are also covered to treat an injury or disease of the eyes.

Q. FACILITY BASED PHYSICIANS

Services provided by a Facility Based Physician or provider in a Hospital or facility when in support of the primary Covered Service are covered under the Agreement. For purposes of this Section, Facility Based Physicians or providers include pathologists, radiologists, anesthesiologists and emergency room physicians when providing services at a Hospital, ambulatory surgery center, or other similar setting.

R. FAMILY PLANNING

Family planning limited to voluntary surgical sterilization, prescription, fitting and insertion of implantable contraceptives and intrauterine birth control devices, including the device or appliance.

S. HEARING AIDS

Hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver.

Benefits are available for a hearing aid that is purchased as a result of a written recommendation by a Network Physician and obtained from a Network Provider. Benefits are provided for the hearing aid and for charges for associated fitting and testing. See your Summary of Benefits for any applicable limits.

Benefits under this section do not include bone anchored hearing aids. Bone anchored hearing aids may be covered under the applicable medical/surgical categories in this Agreement only for Members who have either of the following:

- Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.

- Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

T. HEARING EXAMS

One hearing exam per calendar year for children through age 19 is covered when performed by the Primary Care Physician for the primary purpose of determining the need for hearing correction.

U. IMPLANTS

Implants to restore routine function required as a result of acquired Illness, Injury or surgery such as cardiac defibrillators and pacemakers and cochlear implants, except as excluded in Article VI. Coverage for implants is limited to the most cost effective implant device which meets the Member's medical needs, as determined by NHP.

V. MAMMOGRAPHY SCREENING

Mammography screening performed on dedicated equipment for diagnostic purposes, as follows:

1. One baseline mammogram for women ages 35 through 39.
2. One mammogram for women ages 40 and over, every one to two years.
3. One or more mammograms a year based upon a Network Physician's recommendation for a woman who is at risk for breast cancer because: (i) there is a family history of breast cancer; (ii) there is a history of biopsy-proven benign breast disease; (iii) a mother, sister, or daughter has had breast cancer, or (iv) the woman has not given birth before the age of 30.

W. MASTECTOMY SERVICES

Mastectomy services for breast cancer treatment and outpatient post surgical follow up in accordance with prevailing medical standards. Mastectomy means the removal of all or part of the breast of a Member for Medically Necessary reasons as determined by a Network Physician. Breast reconstructive surgery following Mastectomy to establish contralateral symmetry between the breasts is covered. Breast reconstructive surgery does not include surgery on an otherwise healthy breast to change its size, shape, or appearance, except as stated in the preceding sentence.

X. MATERNITY SERVICES

Service and supplies for maternity related Covered Services are treated the same as any other Illness and/or Injury. Subject to applicable law, services may be provided by certified nurse-midwives, licensed midwives, and birth centers licensed pursuant to Florida law, who are also Network Providers. Coverage includes services for a normal pregnancy, including routine office visits for prenatal and post-delivery care for a mother and her Newborn infant including a postpartum assessment and Newborn assessment and may be provided at the Hospital, at the attending Physician's office, at an outpatient maternity center, or in the home by a qualified licensed healthcare professional trained in mother and baby care. The services include physical assessment of the Newborn and mother, and any Medically Necessary clinical tests and immunizations in keeping with prevailing medical standards. Coverage for the length of a maternity and newborn stay in a Hospital or for follow-up care outside the Hospital will be for the period of time that such care is determined to be Medically Necessary. Medical Necessity will be determined by NHP in accordance with prevailing medical standards and consistent with guidelines for prenatal care of the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, the treating obstetrical care provider or pediatric care provider. Services received from lactation consultants are not covered. The Newborn Child must be enrolled under the Agreement in accordance with Article II, in order for benefits for the Newborn Child to be paid under the Agreement.

Y. NEWBORN CHILDREN

Services for Newborn Children consist of well baby care and diagnosis and treatment of Injury or Illness. This includes the care and treatment of medically diagnosed congenital defects, birth abnormalities, prematurity, and transportation costs of the Newborn to and from the nearest Network facility with the appropriate staff and equipment necessary to protect the health and safety of the Newborn Child. The Newborn Child must be enrolled under the Agreement in accordance with Article II in order for benefits for the Newborn Child to be paid under the Agreement.

Z. ORTHOTICS

Medically Necessary custom-made orthotics for the leg, arm, back and neck. Replacement custom-made orthotics for the leg, arm, back and neck are covered when the Member's Primary Care Physician determines that replacement is necessary to respond to the needs of a growing child.

AA. OSTEOPOROSIS

Diagnosis and treatment of osteoporosis for high-risk individuals is covered. High risk individuals include: (i) estrogen deficient individuals who are at clinical risk for osteoporosis; (ii) individuals who have vertebral abnormalities; (iii) individuals who are receiving long-term glucocorticoid (steroid) therapy or other medications that may case osteoporosis; (iv) individuals who have primary hyperparathyroidism; and (v) individuals who have a family history of osteoporosis.

BB. OUTPATIENT DIAGNOSTIC SERVICES

Outpatient diagnostic services, including radiology, ultrasound, laboratory, pathology, and imaging.

CC. OUTPATIENT RADIATION THERAPY and I.V. CHEMOTHERAPY

Radiation therapy and Intravenous (I.V.), Intramuscular and Subcutaneous Chemotherapy is covered when prescribed by or with the concurrence of a Network Physician and may be subject to Prior Authorization.

DD. OUTPATIENT REHABILITATION AND THERAPIES

Outpatient physical, respiratory, speech, cardiac or occupational therapies for purposes of rehabilitation due to an acquired Illness or Injury that are expected to result in significant improvement within 2 months of the start of treatment are covered. See your Summary of Benefits for limits per calendar year. Multiple therapies received on the same day will be counted as one visit for each therapeutic discipline received. Speech therapy for Autism Spectrum Disorder is also covered. Note: The visit limit does not apply to therapies for Autism Spectrum Disorder.

Outpatient Rehabilitation and Therapies include habilitative services and those services are subject to the requirements stated below.

For the purpose of this Benefit, "habilitative services" means Medically Necessary skilled health care services that help a person keep, learn or improve skills and functioning for daily living. Habilitative services are skilled when all of the following are true:

- The services are part of a prescribed plan of treatment or maintenance program that is Medically Necessary to maintain a Member's current condition or to prevent or slow further decline.
- It is ordered by a Physician and provided and administered by a licensed provider.
- It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.
- It is not Custodial Care.

We will determine if Covered Services are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. Therapies provided for the purpose of general well-being or conditioning in the absence of a disabling condition are not considered habilitative services. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits are provided for habilitative services provided for Members with a disabling condition when both of the following conditions are met:

- The treatment is administered by a licensed speech-language pathologist, licensed audiologist, licensed occupational therapist, licensed physical therapist or Physician.
- The initial or continued treatment must be proven and not Experimental or Investigational.

Benefits for habilitative services do not apply to those services that are solely educational in nature or otherwise paid under state or federal law for purely educational services. Custodial Care, respite care, day care, therapeutic recreation, vocational training and residential treatment are not habilitative services. A service that does not help the Member to meet functional goals in a treatment plan within a prescribed time frame is not a habilitative service.

We may require that a treatment plan be provided, request medical records, clinical notes, or other necessary data to allow us to substantiate that initial or continued medical treatment is needed. When the treating provider anticipates that continued treatment is or will be required to permit the Member to achieve demonstrable progress, we may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated goals of treatment, and how frequently the treatment plan will be updated.

Benefits for Durable Medical Equipment and prosthetic devices, when used as a component of habilitative services, are described under

Durable Medical Equipment and Prosthetic Devices.

EE. PODIATRIC SERVICES

Podiatric services performed by a Network Podiatrist are covered without the need for a referral, except for services excluded in Article VI.

FF. PREVENTIVE CARE SERVICES

Preventive care services provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under applicable law:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*.
- Immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention*.
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.

GG. PROSTHETIC DEVICES

Prosthetic devices to restore normal function required as a result of acquired Illness, covered surgery or Injury, including artificial limbs and eyes to replace natural limbs or eyes lost by a Member while covered under the Agreement and prosthetic devices incident to Mastectomy are covered. Prosthetic devices (except for prosthetic devices incident to Mastectomy) are limited to one permanent prosthesis (including a temporary prosthesis when Medically Necessary) prescribed for the Injury, Illness or surgery, except that replacement of prosthetic devices which are functionally necessary to respond to the needs of a growing child are covered. Replacement of damaged or lost prosthetic devices is excluded from coverage. Coverage for Prosthetic Devices is limited to the most cost effective prosthetic device which meets the Member's medical needs, as determined by NHP. Bionic devices are not covered.

HH. RECONSTRUCTIVE SURGERY

Reconstructive surgery required to correct a functional abnormality resulting from trauma, acquired disease or congenital deformity.

II. SECOND MEDICAL OPINION

If you dispute our response or a Network Physician's opinion to the reasonableness or necessity of surgical procedures or you are subject to a serious Sickness, you may obtain a second opinion from one of the following:

- Network Physician listed in our provider directory or by going to www.myNHP.com or by calling Customer Service at the telephone number on your ID Card.
- A Non-Network Physician located within our Service Area.
- In the case of a second opinion from a Network Physician, such second opinions are considered Covered Health Services. In the case of a second opinion from a Non-Network Physician, Covered Health Services shall be limited to 60% of Eligible Expenses. If the Non-Network Physician requires any tests during the second opinion process, you must have such tests performed by a Network provider.
- In the event that you seek more than three second opinion referrals in a calendar year and we determine that you are unreasonably over-utilizing the second opinion privilege, we may deny reimbursement of expenses incurred after three referrals.

JJ. TEMPOROMANDIBULAR JOINT SERVICES

Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ) and associated muscles.

- Diagnosis: Examination, radiographs and applicable imaging studies and consultation.
- Non-surgical treatment including clinical examinations, oral appliances (orthotic splints), arthrocentesis and trigger-point injections.

Benefits are provided for surgical treatment if the following criteria are met:

- There is clearly demonstrated radiographic evidence of significant joint abnormality.
- Non-surgical treatment has failed to adequately resolve the symptoms.
- Pain or dysfunction is moderate or severe.

Benefits for surgical services include arthrocentesis, arthroscopy, arthroplasty, arthrotomy and open or closed reduction of dislocations.

KK. URGENT CARE SERVICES

When provided by a Network Provider in the Service Area or a Non-Network Provider outside the Service Area and when it is not reasonable or practical to wait to see the Primary Care Physician.

LL. VIRTUAL VISITS

For Covered Health Services that include the diagnosis and treatment of low acuity medical conditions for Members through the use of interactive audio and video telecommunication and transmissions, and audio-visual communication technology. Virtual visits provide communication of medical information in real-time between the patient and a distant Physician or health specialist, through use of interactive audio and video communications equipment outside of a medical facility (for example, from home or from work).

Network Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to www.myNHP.com or by calling *Customer Care* at the telephone number on your ID card.

Please Note: Not all medical conditions can be appropriately treated through virtual visits. The Designated Virtual Network Provider will identify any condition for which treatment by in-person Physician contact is necessary.

Benefits under this section do not include email, fax and standard telephone calls, or for telehealth/telemedicine visits that occur within medical facilities (CMS defined originating facilities).

MM. VISION SCREENING

One Vision screening per calendar year for children through age 19 when performed by the Primary Care Physician.

ARTICLE V - EMERGENCY MEDICAL CONDITIONS IN OR OUT OF THE SERVICE AREA

A. EMERGENCY SERVICES AND CARE

Emergency Services and Care in or out of the Service Area are covered under the Agreement subject to the applicable Copayment. Emergency Services and Care provided to a Member in an emergency situation that does not permit treatment through Network Providers are covered under the Agreement without prior notification to or approval of NHP. Benefits for treatment and services of Emergency medical conditions received from Non-Network Providers will be paid in accordance with the definition of "Eligible Expenses" in Article I. All claims and supporting documentation must be submitted to NHP in English.

B. NOTIFICATION UPON HOSPITALIZATION

If a Member is hospitalized with an Emergency Medical Condition, the Member, or the Subscriber in the case of a minor Member, should notify NHP within 48 hours of the Member's hospitalization. In the case of a Member who, by reason of medical condition, is unable to communicate, notification is required as soon as reasonably possible once the Member regains the ability to communicate. If a Member fails to notify NHP within 48 hours after the emergency occurred when it was reasonably possible to do so, coverage will be denied.

C. HOSPITAL, MEDICAL AND SURGICAL SERVICES

Treatment and services as described in the Agreement are covered for Emergency Medical Conditions.

D. AMBULANCE SERVICES

Ambulance service to the nearest Network facility as a result of an Emergency Medical Condition is a Covered Service.

E. EMERGENCY ROOM

Emergency room services for Emergency Medical Conditions are covered subject to applicable Copayment amounts. The Copayment is waived if the Member is admitted to the Hospital as a result of the Emergency Medical Condition.

F. HOSPITAL TRANSFER

NHP may elect to transfer the Member to a Network Hospital if the Member is hospitalized in a non-Network Hospital as soon as the Member is medically stable after the Emergency Medical Condition. NHP may further elect to transfer the Member between Network Hospitals if NHP determines such transfer to be medically appropriate under the circumstances. If a Member refuses transfer that is otherwise medically appropriate, then all charges incurred for provision of services to Member as of the requested transfer date will be at the Member's own expense.

G. FOLLOW-UP CARE

Care in follow-up to Emergency Services and Care must be received, prescribed, directed or Prior Authorized by the Member's Primary Care Physician.

ARTICLE VI - EXCLUSIONS AND LIMITATIONS

No benefits or coverage are provided for the following:

A. EXCLUSIONS

1. Services that are not provided, arranged or Prior Authorized by a Primary Care Physician and/or NHP, except in the case of an Emergency Medical Condition, or for services set forth in Article V for which direct access to Participating Providers is expressly permitted.
2. Services that are not Medically Necessary.
3. Non-emergency health services received from Non-Network Providers not Prior Authorized by NHP.
4. Any expenses related to a Member staying in a Hospital, Skilled Nursing Facility or other facility past the discharge time or date set by NHP or a Network Physician, after notice to the Member.
5. Any service or supply received in connection with a facility or program operated, or for which payment is made, by federal or state government or any agency or subdivision and/or when a Member has no legal obligation for payment, or to the extent that payment has been made in accordance with Article VII, Coordination of Benefits.
6. Services for personal comfort or convenience of the Member including television, newspaper, or telephone.
7. Private Hospital room unless Prior-Authorized by NHP. In circumstances where the private room is not Prior-Authorized, NHP will not be responsible for the private room surcharge.
8. Corsets, foot orthotics, shoes (including without limitation orthopedic shoes and diabetic footwear), shoe inserts, oral appliances, cranial molding helmets, and over-the-counter cam boots and cam walkers or similar prefabricated devices. Replacement custom-made orthotics due to loss or damage are not covered.
9. Items or services that are primarily Custodial Care, training or supervision in personal hygiene, and other forms of self-care to a Member who does not require skilled medical or nursing services, including services provided in or by rest homes, companions, sitters, domestic maids, home mothers or respite care, except for Hospice Services.
10. Medication, supplies and equipment which Member takes home from the Hospital or other facility:
11. Any medical or surgical treatment or related services the primary purpose of which is to improve appearance, such as cosmetic surgery, including but not limited tattoos, liposuction, ear piercing, care and treatment of complication(s) resulting from services that are not otherwise covered:
12. Keloid removal, radiation, injection or any form of treatment for keloids.
13. Ambulance services, except as expressly authorized in Article IV and V.
14. Autopsy.
15. Dental evaluation and/or treatment, including any services or supplies involving repair, replacement or removal of teeth, the care of gums or other supporting structures of teeth, the preparation of the mouth for dentures, intraoral prosthetic devices, improvement of dental occlusion, or surgical procedures that are cosmetic in nature. This exclusion does not apply to accidental injury to sound natural teeth or Cleft Lip or Cleft Palate Treatment Services described in Article IV.
16. Counseling for family or marital problems.
17. Treatment or evaluation (including, without limitation, speech, physical and occupational therapy) of learning disabilities, intellectual disabilities, and developmental disorders or delay including learning disorders, motor skills disorders, communication disorders, and autistic disorders.

18. Vision care, including examinations in connection with corrective lenses, or for the purchase of eye glasses, or contact lenses, or for services relating to radial keratotomy or lasik or other surgical procedure to correct myopia (nearsightedness), hyperopia (farsightedness) or stigmatic error, or training or orthoptics. Intraocular lenses at the time of cataract surgery are limited to traditional lenses. Premium lenses are not covered.

19. Items or services determined to be Investigational, Experimental or Obsolete. This exclusion does not apply to medically appropriate medications prescribed for the treatment of cancer. The drug must be recognized for the treatment of that indication and published within a standard reference compendium or recommended in medical literature.

20. Examinations for insurance, employment, flight physical, travel or School, unless the service is within the scope of, and coincides with, a periodic health assessment as provided in Article IV, or services provided to evaluate scholastic and/or occupational ability, performance or potential.

21. Treatment, services or supplies related to a work related Illness or Injury are excluded to the extent the Member is covered by Workers' Compensation, except for Medically Necessary services (not otherwise excluded) for a Member who is not covered by Workers' Compensation and that lack of coverage did not result from any intentional action or omission by the Member.

22. Reversals of voluntary sterilizations.

23. Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment. Excluded infertility treatments include artificial insemination, In Vitro Fertilization (IVF), Gamete Intrafallopian Transfer (GIFT), Zygote Intrafallopian Transfer (ZIFT), embryo transport; surrogate parenting; donor semen: semen collection and preparation costs; or infertility medications and surgical procedures to correct infertility or other methods of assisted fertilization. This exclusion does not apply to services required to treat or correct underlying causes of infertility.

24. Termination of pregnancy unless Medically Necessary for the physical health of the mother or in the presence of documented fetal abnormalities.

25. Long term physical (including without limitation, chest physiotherapy), respiratory, occupational, cardiac or speech therapy, other than limited visits for Physical Rehabilitation as described in your Summary of Benefits. Therapy for chronic conditions or maintenance therapy is not covered. In addition, therapy for a condition(s) that has not shown significant improvement in a relatively short time is not covered.

26. Any items or services ordered by a court of law, unless otherwise covered under the Agreement.

27. Items or services incurred as a result of voluntary participation in an assault, felony, insurrection or riot or arising during a period of detainment by law enforcement officers or incarceration.

28. Vision screening, except for children through age 19 when performed by the Primary Care Physician.

29. Bone anchored hearing aids except when either of the following applies:

    - For Members with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.
    - For Members with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

    More than one bone anchored hearing aid per Member who meets the above coverage criteria during the entire period of time the Member is enrolled under this Agreement.

    Repairs and/or replacement for a bone anchored hearing aid for Members who meet the above coverage criteria, other than for malfunctions.

30. Complementary/Alternative healing methods, including acupuncture, colonic irrigations, acupressure, massage, hypnosis, biofeedback, homeopathy, environmental medicine, thermography, mind-body interactions such as meditation, imagery, yoga, dance and art therapy, manual healing methods, herbal therapies or other alternative medicine as determined by NHP.

31. Any medical or surgical treatment whose primary purpose is to correct complications as a result of the Member's willful and knowing failure to follow the treatment plan of the Physician.

32. Services whose primary purpose is for routine foot care including the trimming of corns, calluses, nails or bunions; treatment of flat feet, fallen arches, chronic foot strain, or supplies, including shoes, orthopedic shoes, arch supports, orthotics or similar supplies for the support of feet.

33. Services for cessation of smoking or educational programs to assist in health maintenance or improvement, unless such services are pre-approved by NHP or are for diabetes outpatient self-management training or diabetes educational services.

34. Pre-natal or childbirth classes.

35. Services, including psychiatric services, whose primary purpose is the treatment of sexual dysfunction, gender change, sexual reassignment treatment or modifications or treatment for gender identity disorders or medical or surgical treatment to improve or restore sexual function.

36. Care, treatment or services performed by a resident of the Member's household or from anyone related to the Member by blood or marriage.

37. Inpatient Hospital Services for substance use treatment unless for detoxification and treatment of acute withdrawal symptoms.

38. Private or special duty nursing care. For the purposes of this exclusion, private duty nursing care includes services for Members who require more individual and continuous care than is available from a visiting nurse through a Home Health Care Agency. Private duty nursing services are provided where durations of longer skilled nursing care (typically more than 4 hours) are required and may include shift care or continuous care in certain settings.

39. Emergency room and related medical services for Illness or injury that are not for an Emergency Medical Condition.

40. Services or treatment provided by a person or facility that is not properly approved or licensed as required by applicable law.

41. Charges for out-of-network or out-of-Service Area services that exceed Eligible Expenses. This does not apply to services provided for an emergency medical condition.

42. The purchase or rental of air conditioners, humidifiers, dehumidifiers, air purifiers, whirlpools, jacuzzis, swimming pools, water beds, motorized transportation equipment, escalators, elevators, or other similar items or equipment or sports related devices.

43. Services for the treatment of obesity, including surgical operations and medical treatment.

44. Any services not specifically stated as a Covered Service in the Agreement, unless such services are specifically required to be covered by state or federal law.

45. Medical or surgical treatment and/or evaluation of complications arising from any non-covered services including physician and facility charges.

46. Travel or lodging expenses of any kind, unless related to organ transplant services that are approved in advance and in writing by NHP.

47. Charges incurred prior to the Effective Date of coverage or on or after the date coverage is terminated, except as specifically stated under Extension of Benefits, Article II.

48. Treatment of any Illness or Injury due to war or any act of war, declared or undeclared, and any Illness or Injury due to service in the armed forces. For purposes of the Agreement, war does not include terrorism.

49. Pre-conception or genetic testing or counseling, except for genetic testing and/or counseling performed during pregnancy for suspected fetal abnormality when Prior Authorized by NHP. Genetic testing is not covered when the results will not directly impact the diagnosis or treatment of the covered member.

50. Confinement, treatment, service or supply for which a Member has no financial liability or that would be provided at no charge in the absence of insurance.

51. Prescription medications or items for outpatient treatment, over-the-counter drugs, medicines, supplies, vitamins, enteral formulas, nutritional supplies or food; or any other equipment, including heating pads, blood pressure cuffs and compression stockings, except for coverage of Enteral Formula as described in Article III.

52. Illness or Injury resulting from participation in the following hazardous recreational activities including bungee jumping, sky diving, scuba diving at depths below 60 feet or scuba diving without prior professional certification (such as PAD1), hang-gliding, auto racing, mountain climbing, and rock climbing.

53. Drugs prescribed for uses other than approved by the United States Food and Drug Administration (FDA).

54. Weight control, weight loss, health and fitness programs, gastric stapling, gastric bypass, gastric banding, gastric bubbles, and other procedures for the treatment of obesity, morbid obesity, or any other diagnoses co-morbid with obesity or morbid obesity.

55. Outpatient vestibular therapy, brain injury therapy or visual therapy.

56. Nutritional consultants, except for Diabetes as set forth in Article IV. This exclusion does not apply to preventive care for which Covered Services are provided under the *United States Preventive Services Task Force* requirement.

57. Circumcision, except for circumcisions performed within 30 days of birth or when medically necessary.

58. Medical or surgical treatment for gynecomastia related to weight, hormonal, or growth development.

59. Replacement of damaged or lost prosthetic devices.

60. Bionic devices.

61. Costs associated with the surgical or medical care and treatment of erectile dysfunction, including penile implants/ prosthesis and surgery to insert penile implant/prosthesis, regardless of cause of such erectile dysfunction. Replacement, removal or repair of a previous implant or prosthesis is excluded from coverage.

62. Family planning, except as otherwise expressly covered in this Handbook.

63. Wigs or other cranial prosthetics.

64. Services received while on active military duty and services for treatment of military service-related disabilities, when the Member is legally entitled to other coverage and facilities are reasonably available.

65. Orthomolecular therapy, nutrients and food supplements.

66. Treatment of a condition or complications from a condition resulting, directly or indirectly, from a Member being under the influence of alcohol or due to illegal drug use.

67. Transplant services when: (a) NHP is not contacted for authorization within a reasonable time prior to referral for transplant evaluation for the procedure; (b) when the transplant procedure is performed in a facility that has not been designated by NHP as an approved transplant facility; (c) when expenses related to the transplant are eligible for reimbursement under any private or

public research fund, government program or other funding program; or (d) when the transplant is for a non-human organ or tissue. Donor costs related to the removal of an organ from a Member for the purpose of transplantation into a recipient who is not a Member are not covered.

68. Work or travel vaccines and immunizations.

69. Benefits for treatment and services of Emergency medical conditions received from Non-Network Providers will be paid in accordance with the definition of "Eligible Expenses" in Article I. All claims and supporting documentation must be submitted to NHP in English.

70. Personal Care, Comfort or Convenience. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:

- Air conditioners, air purifiers and filters and dehumidifiers.
- Batteries and battery chargers.
- Breast pumps. This exclusion does not apply to breast pumps for which Benefits are provided under the Health Resources and Services Administration (HRSA) requirement.
- Car seats.
- Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts and recliners.
- Exercise equipment.
- Home modifications such as elevators, handrails and ramps.
- Hot tubs.
- Humidifiers.
- Jacuzzis.
- Mattresses.
- Medical alert systems.
- Motorized beds.
- Music devices.
- Personal computers.
- Pillows.
- Power-operated vehicles.
- Radios.
- Saunas.
- Stair lifts and stair glides.
- Strollers.
- Safety equipment.
- Treadmills.
- Vehicle modifications such as van lifts.
- Video players.
- Whirlpools.

B. LIMITATIONS

The following limitations are in addition to any limitation or exclusion described in the Agreement or the Summary of Benefits.

1. ***Major Disasters***

In the event of any major disaster, epidemic, war, riot or civil insurrections, the Network Physicians will render medical services and arrange for hospital services insofar as practical according to their best judgment, within the limitation of such facilities and personnel as are then available. Neither NHP nor its Physicians will have any liability or obligation for delay or failure to provide medical services or arrange for hospitalization due to lack of available facilities or personnel if such lack is the result of conditions arising out of the social or environmental disturbances specified in this paragraph.

ARTICLE VII - COORDINATION OF BENEFITS AND SUBROGATION

A. COORDINATION OF BENEFITS APPLICABILITY

If a Member is covered by more than one group health plan or insurance program (plan or program referred to as "plan(s)"), then this Coordination of Benefits provision controls which plan or insurance carrier will be the primary payer and which will be secondary payer.

When coordinating benefits, one of the two or more plans involved is the primary plan which is required to pay its full benefit and the other plan is the secondary plan (or tertiary plan, as the case may be). Payments from secondary/tertiary plans are coordinated so that the total of the payments from all plans are not more than 100% of the amount owed by NHP for benefits under the Agreement (i.e. the amount NHP would have paid if primary).

Any plan without a Coordination of Benefits provision is automatically designated as the primary plan. Where the applicable plans all have coordination of benefits provisions, NHP will determine the order of benefits by using the first of the following rules that applies:

1. The benefits of the plan covering the person as an employee are determined before those of the plan covering the person as a Dependent.

2. For Employers with 20 or more employees, if the person is also a Medicare beneficiary, and if the rule established under the Social Security Act of 1965, as amended, makes Medicare secondary to the plan covering the person as an active employee or Dependent, the order of benefit determination is:

    a. First, benefits of a plan covering a person as an employee, member, or subscriber.

    b. Second, benefits of a plan of an active worker covering a person as a Dependent.

    c. Third, Medicare benefits.

3. Except as provided in paragraph 4, when more than one plan covers the same child as a Dependent of different parents, the following applies:

    a. The benefits of the policy or plan of the parent whose birthday, excluding the year of birth, falls earlier in the year are determined before the benefits of the policy or plan of the parent whose birthday, excluding the year of birth, falls later in that year; but

    b. if both parents have the same birthday, the benefits of the policy or plan which covered the parent for a longer period of time are determined before those of the policy or plan which covered the parent for a shorter period of time.

    However, if a policy or plan subject to the rule based on the birthdays of the parent coordinates with an out of state policy or plan which contains provisions under which the benefits of a police or plan which covers a person as a Dependent of a male are determined before those other policy or plan which covers the person as a Dependent of a female, and if, as a result, the policies or plans do not agree on the order of benefits, the provisions of the other policy or plan determine the order of benefits.

4. Where two or more plans cover a Dependent child of divorced or separated parents, the benefits for the child are determined in this order:

    a. First, the plan of the parent with custody of the child;

    b. Second, the plan of the spouse of the parent with the custody of the child; and

    c. Finally, the plan of the parent who does not have custody of the child.

    However, if the terms of a court decree stipulate that one of the parents is responsible for the child's healthcare expenses, and if the entity obliged to provide benefits under the plan of that parent has actual knowledge of the terms of such decree, the benefits of that plan are determined first. This order of benefits does not apply to any claim determination

period or calendar year when benefits are actually paid or provided before the entity has actual knowledge of the terms of the court decree.

For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, rule 6 below applies.

In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule above to the dependent child's parent(s) and the dependent's spouse.

5. The benefits of a plan which covers a person as an employee who is neither laid-off nor retired, or as that employee's Dependent, are determined before those of a policy or plan which covers the person as a laid-off or retired employee or as the employee's Dependent. If the other policy or plan is not subject to this rule, and if, as a result, the policies or plans do not agree on the order of benefits, this paragraph does not apply.

6. If rules 1-5 do not determine the order of benefits, the benefits of a plan covering a person for a longer period of time are determined before those of the plan covering the shorter time.

7. If a person is covered under a COBRA continuation plan as a result of the purchase of coverage as provided under the Consolidation Omnibus Budget Reconciliation Act of 1987 (Pub. L. No. 99-272), and also under another group plan, the following order of benefits applies:

   a. First, the plan covering the person as an employee or as the employee's Dependent;

   b. Second, the coverage purchased under the plan covering the person as a former employee, or as the former employees Dependent pursuant to the provisions of COBRA.

8. NHP may coordinate benefits under the following types of contracts:

   a. any group or group-type insurance or HMO;

   b. any plan or insurance policy, including automobile insurance policy, provided that such plans contain coordination of benefits provisions;

   c. Medicare, as allowed by law.

9. NHP will not coordinate benefits against indemnity-type policy (regardless of whether such indemnity-type policy is an individual policy, group blanket policy or group franchise policy), an excess insurance policy as defined in Florida Statutes, Chapter 627.635, a policy with coverage limited to specified illnesses or accidents, or a Medicare supplement policy.

10. The Coordination of Benefit rules set forth above apply whether or not the Member files a claim under the plans.

The Covered Services rendered pursuant to the Agreement are primary to any services for which a Member may be eligible to receive under the Medicaid program.

B. RIGHT TO RECOVER

NHP is entitled to recover from the Member amounts that are overpaid to him or for him for medical services provided under the Agreement.

C. TIME LIMIT FOR PAYMENT

Payment of benefits due under any plan, subject to this Article, will be made in accordance with the time frames listed in Section 641.3155, Florida Statutes, unless NHP provides the claimant a clear and concise statement of a valid reason for further delay which is in no way caused by the existence of a COBRA provision nor otherwise attributable to NHP claiming delay.

D. FACILITY OF PAYMENT AND RECOVERY

1. Whenever payments that should have been made under the Agreement have been made under any other plans, NHP will have the right to pay that amount to the organization that made such payments. That amount will then be

treated as though it was a benefit paid under the Agreement. NHP will not have to pay that amount again. The term "payment" includes providing benefits in the form of services, in which case "payment" means reasonable cash value of the benefits provided in the form of services.

2. If the amount of the payment made by NHP, including the reasonable cash value of any benefits provided in the form of services, is more than it should have paid under the Agreement, it may recover the excess payments from among one or more of the following, as the Agreement will determine: 1) any persons to or for or with respect to whom such payments were made; and 2) any other insurers, service plans or any other organizations.

E. SUBROGATION AND REIMBURSEMENT

1. ***Subrogation and Reimbursement***. Generally, in the event that the Member recovers damages from a third party or first party insurer (i.e. uninsured motorist coverage) due to any negligent act or omission of the third party. NHP will, to the extent of medical benefits or payments provided to or on behalf of the Member, retain a right of reimbursement or be subrogated to the Member's rights of recovery arising out of any claim or cause of action related to such third party's negligent act or omission, including the proceeds of first party coverage.

2. ***Filing a Claim Against a Third Party and Other Action***. In the event that a Member files a claim, lawsuit or otherwise seeks to recover damages from any party arising from the negligent act or omission of a third party, the Member will include in such lawsuit a claim for the medical benefits or payments provided to or on behalf of the Member by NHP. A Member will take such action, furnish such information and assistance and execute and deliver all instruments to NHP or such other party as NHP may require to enforce its reimbursement and/or subrogation rights under the Agreement.

3. ***Allocation of Proceeds***. To the extent that a Member which NHP has provided medical benefits or payments to, or on behalf of, due to injury, disease, or illness by virtue of the intentional or negligent act or omission of a third party, recovers any monies as a result of judgment, settlement or otherwise from any party, including first party insurer. NHP will be entitled to reimbursement or subrogation in accordance with Florida law and the applicable allocation of proceeds that appear below, or such other allocation as the Member may adopt, whichever is greater. For purposes of the Agreement, any settlement or judgment received by a Member is deemed full and complete compensation for any injury disease, or illness suffered as virtue of the negligent act or omission of a third party.

   (a) If the total amount recovered from all such third party recoveries is less than or equal to 150% of the amount of medical benefits or payments provided by NHP to or on behalf of the Member, the Member will designate a portion of any such settlement, judgment or other third party recovery among such medical benefits or payments and other reasonable damages sustained by the Member according to the proportion that medical benefits or payments provided by NHP to, or on behalf of, the Member bears to the total amount of the Member's recovery for purposes of determining NHP's entitlement to reimbursement or subrogation.

   (b) If the total amount recovered from all recoveries is greater than 150% of the amount of medical benefits or payments provided by NHP to or on behalf of the Member, the Member specifically agrees to designate a portion of any such recovery sufficient to fully reimburse NHP for the amount of medical benefits or payments provided by NHP to or on behalf of the Member for purposes of determining NHP's entitlement to reimbursement or subrogation under Florida law.

4. ***Attorneys' Fees and Other Costs***. In the event that NHP engages an attorney or other agent for purposes of enforcing its subrogation or reimbursement rights as stated in this provision against a Member's failure to cooperate with NHP, the prevailing party in any legal action or other proceeding brought to enforce such rights will be entitled to an award of its costs, including, without limitation, reasonable attorneys' fees associated with enforcement of its subrogation or reimbursement rights.

5. ***Survival of Rights***. In the event that any or all of NHP's subrogation or reimbursement rights as set forth in the Agreement are found by a court to be unenforceable for any reason, such a finding will not affect the validity or enforceability of any provision of the Agreement not specifically addressed by such Court, nor will such a finding affect NHP's rights to reimbursement or subrogation under Florida law.

6. ***Notice Right of Intervention***. The Subscriber will provide NHP with timely written notification in the event that the Subscriber or any Member related to the Subscriber suffers injury, disease, or illness by virtue of the negligent act or omission of a third party. Such a notice must inform NHP: (i) of the nature of the injury, disease, or illness; (ii) of the name(s) and addresses (if available) of the third party(ies); (iii) of the names, addresses and phone numbers of any insurance companies or other third parties who may be responsible for payment of damages suffered by the Member; (iv) a description of the accident or occurrence that the Member reasonably believes was responsible for the injury, disease, or illness at issue and the approximate date(s) upon which such accident or occurrence occurred; and (v) the name of any legal counsel retained by a Member in connection with any such accident or occurrence. In the event that a Member brings a lawsuit, counterclaim, cross-claim or any other action in connection with any such accident or occurrence, Member or Member's counsel is required to notify NHP if the Member intends to claim damages from the third party for the injuries or illness. NHP will be provided with copies of all pleadings, notices and other documents and papers that relate to NHP's rights of reimbursement or Subrogation under the Agreement. NHP reserves the right to intervene in any proceeding in which a Member is a party to the extent that such intervention is reasonably necessary to protect NHP's rights of reimbursement or subrogation under the Agreement.

Members will fully cooperate with NHP regarding the NHP's exercise of its rights to Coordination of Benefits and Subrogation, and will cooperate with NHP's actions to administer benefits. Member will execute and submit such consents, releases, assignments and other documents as may be requested by NHP. Failure to provide such documents will be a basis for termination of the Agreement.

ARTICLE VIII - COMPLAINTS AND APPEALS, PRIOR APPROVALS AND CLAIMS

To resolve a question, complaint, or appeal, just follow these steps:

What to Do if You Have a Question

Contact Customer Service at the telephone number shown on your ID card. Customer service representatives are available to take your call during regular business hours, Monday through Friday.

What to Do if You Have a Complaint

Contact Customer service at the telephone number shown on your ID card. Customer service representatives are available to take your call during regular business hours, Monday through Friday.

If you would rather send your complaint to us in writing, the Customer Service representative can provide you with the appropriate address.

If the Customer Service representative cannot resolve the issue to your satisfaction over the phone, he/she can help you prepare and submit a written complaint. We will notify you of our decision regarding your complaint within 60 days of receiving it.

How to Appeal a Claim Decision

Post-service Claims

Post-service claims are those claims that are filed for payment of Benefits after medical care has been received.

Pre-service Requests for Benefits

Pre-service requests for Benefits are those requests that require prior notification or benefit confirmation prior to receiving medical care.

How to Request an Appeal

If you disagree with either a pre-service request for Benefits determination, post-service claim determination or a rescission of coverage determination, you can contact us in writing to formally request an appeal.

Your request for an appeal should include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to us within 180 days after you receive the denial of a pre-service request for Benefits or the claim denial.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field, who was not involved in the prior determination. We may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records and other information relevant to your claim for Benefits. In addition, if any new or additional evidence is relied upon or generated by us during the determination of the appeal, we will provide it to you free of charge and sufficiently in advance of the due date of the response to the adverse benefit determination.

Appeals Determinations

Pre-service Requests for Benefits and Post-service Claim Appeals

For procedures associated with urgent requests for Benefits, see *Urgent Appeals that Require Immediate Action* below.

You will be provided written or electronic notification of the decision on your appeal as follows:

- For appeals of pre-service requests for Benefits as identified above, the first level appeal will be conducted and you will be

notified of the decision within 15 days from receipt of a request for appeal of a denied request for Benefits. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. Your second level appeal request must be submitted to us within 60 days from receipt of the first level appeal decision. The second level appeal will be conducted. If you are unable to attend, you will be notified of the decision within 15 days from receipt of the second level request.

- For appeals of post-service claims as identified above, the first level appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied claim. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. Your second level appeal request must be submitted to us within 60 days from receipt of the first level appeal decision. The second level appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for review of the first level appeal decision.

Please note that our decision is based only on whether or not Benefits are available under the Group Service Agreement for the proposed treatment or procedure.

You may have the right to external review through *an Independent Review Organization (IRO)* upon the completion of the internal appeal process. Instructions regarding any such rights, and how to access those rights, will be provided in our decision letter to you.

Urgent Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health, or the ability to regain maximum function, or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your Physician should call us as soon as possible.
- We will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.
- If we need more information from your Physician to make a decision, we will notify you of the decision by the end of the next business day following receipt of the required information.

The appeal process for urgent situations does not apply to prescheduled treatments, therapies or surgeries.

Federal External Review Program

If, after exhausting your internal appeals, you are not satisfied with the determination made by us, or if we fail to respond to your appeal in accordance with applicable regulations regarding timing, you may be entitled to request an external review of our determination.

If one of the above conditions is met, you may request an external review of adverse benefit determinations based upon any of the following:

- Clinical reasons.
- The exclusions for Experimental or Investigational Services or Unproven Services.
- Rescission of coverage (coverage that was cancelled or discontinued retroactively).
- As otherwise required by applicable law.

You or your representative may request a standard external review by sending a written request to the address set out in the determination letter. You or your representative may request an expedited external review, in urgent situations as detailed below, by calling the toll-free number on your ID card or by sending a written request to the address set out in the determination letter. A request must be made within four months after the date you received our decision.

An external review request should include all of the following:

- A specific request for an external review.

- The Member's name, address, and insurance ID number.
- Your designated representative's name and address, when applicable.
- The service that was denied.
- Any new, relevant information that was not provided during the internal appeal.

An external review will be performed by an *Independent Review Organization (IRO)*. We have entered into agreements with three or more *IRO*s that have agreed to perform such reviews. There are two types of external reviews available:

- A standard external review.
- An expedited external review.

Standard External Review

A standard external review is comprised of all of the following:

- A preliminary review by us of the request.
- A referral of the request by us to the *IRO*.
- A decision by the *IRO*.

Within the applicable timeframe after receipt of the request, we will complete a preliminary review to determine whether the individual for whom the request was submitted meets all of the following:

- Is or was covered under the Policy at the time the health care service or procedure that is at issue in the request was provided.
- Has exhausted the applicable internal appeals process.
- Has provided all the information and forms required so that we may process the request.

After we complete the preliminary review, we will issue a notification in writing to you. If the request is eligible for external review, we will assign an *IRO* to conduct such review. We will assign requests by either rotating claims assignments among the *IRO*s or by using a random selection process.

The *IRO* will notify you in writing of the request's eligibility and acceptance for external review. You may submit in writing to the *IRO* within ten business days following the date of receipt of the notice additional information that the *IRO* will consider when conducting the external review. The *IRO* is not required to, but may, accept and consider additional information submitted by you after ten business days.

We will provide to the assigned *IRO* the documents and information considered in making our determination. The documents include:

- All relevant medical records.
- All other documents relied upon by us.
- All other information or evidence that you or your Physician submitted. If there is any information or evidence you or your Physician wish to submit that was not previously provided, you may include this information with your external review request and we will include it with the documents forwarded to the *IRO*.

In reaching a decision, the *IRO* will review the claim anew and not be bound by any decisions or conclusions reached by us. The *IRO* will provide written notice of its determination (the "*Final External Review Decision*") within 45 days after it receives the request for the external review (unless they request additional time and you agree). The *IRO* will deliver the notice of *Final External Review Decision* to you and us, and it will include the clinical basis for the determination.

Upon receipt of a *Final External Review Decision* reversing our determination, we will immediately provide coverage or payment for the Benefit claim at issue in accordance with the terms and conditions of the Policy, and any applicable law regarding plan remedies. If the *Final External Review Decision* is that payment or referral will not be made, we will not be obligated to provide Benefits for the health care service or procedure.

Expedited External Review

An expedited external review is similar to a standard external review. The most significant difference between the two is that the time periods for completing certain portions of the review process are much shorter, and in some

instances you may file an expedited external review before completing the internal appeals process.

You may make a written or verbal request for an expedited external review if you receive either of the following:

- An adverse benefit determination of a claim or appeal if the adverse benefit determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function and you have filed a request for an expedited internal appeal.
- A final appeal decision, if the determination involves a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function, or if the final appeal decision concerns an admission, availability of care, continued stay, or health care service, procedure or product for which the individual received emergency services, but has not been discharged from a facility.

Immediately upon receipt of the request, we will determine whether the individual meets both of the following:

- Is or was covered under the Policy at the time the health care service or procedure that is at issue in the request was provided.
- Has provided all the information and forms required so that we may process the request.

After we complete the review, we will immediately send a notice in writing to you. Upon a determination that a request is eligible for expedited external review, we will assign an *IRO* in the same manner we utilize to assign standard external reviews to *IRO*s. We will provide all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the assigned *IRO* electronically or by telephone or facsimile or any other available expeditious method. The *IRO*, to the extent the information or documents are available and the *IRO* considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the *IRO* will review the claim anew and not be bound by any decisions or conclusions reached by us. The *IRO* will provide notice of the final external review decision for an expedited external review as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the *IRO* receives the request. If the initial notice is not in writing, within 48 hours after the date of providing the initial notice, the assigned *IRO* will provide written confirmation of the decision to you and to us.

You may contact us at the toll-free number on your ID card for more information regarding external review rights, or if making a verbal request for an expedited external review.

Claims When You Receive Covered Health Services from a Network Provider

We pay Network providers directly for your Covered Health Services. If a Network provider bills you for any Covered Health Service, contact us. However, you are responsible for meeting any applicable deductible and for paying any required Copayments and Coinsurance to a Network provider at the time of service, or when you receive a bill from the provider.

Claims When You Receive Covered Health Services from a Non-Network Provider

When you receive Covered Health Services from a non-Network provider, you are responsible for requesting payment from us. You must file the claim in a format that contains all of the information we require, as described below.

You should submit a request for payment of Benefits within 90 days after the date of service. If you don't provide this information to us within one calendar year of the date of service, Benefits for that health service will be denied or reduced, as NHP determines. This time limit does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Required Information for Claims

When you request payment of Benefits from us, you must provide us with all of the following information:

- The Subscriber's name and address.
- The patient's name and age.
- The number stated on your ID card.
- The name and address of the provider of the service(s).
- The name and address of any ordering Physician.
- A diagnosis from the Physician.
- An itemized bill from your provider that includes the *Current Procedural Terminology* (CPT) codes or a description of each charge.
- The date the Injury or Sickness began.
- A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

The above information should be filed with us at the address on your ID card.

ARTICLE IX - GENERAL PROVISIONS

Covered Services provided by the Network Provider will be paid directly to the Network Provider of service. If Member has already paid Network Provider, Member must seek reimbursement from such Provider for Covered Services paid to Network Provider by NHP. Benefits will not be paid directly to any Members except reimbursement for payments made by the Member to a Non-Network Provider for which NHP was liable at the time of payment. As soon as practical, the person making claim for cash reimbursement for benefits provided under provisions of the Agreement will give to NHP written proof of claim including full particulars of the nature and extent of the Illness, Injury or condition and treatment received, and any other information that may assist NHP in determining the amount due and payable.

A. NHP may use and disclose certain General Patient Information for routine purposes in accordance with NHP's confidentiality policy and pursuant to the Member's routine consent for the use and disclosure of General Patient Information which is provided when the Member signs the Enrollment Form. Such routine purposes will include application of the coordination of benefits rules and determination of payment obligations under such rules; payment of claims; coordination of care; risk management; peer review procedures; quality assessment, measurement and improvement; utilization management, and case management.

   The Member or Subscriber will provide NHP with all information needed to determine NHP's payment obligations under the coordination of benefits rules within a reasonable time frame from NHP's request. NHP may also obtain the necessary information from other organizations or persons. Further, NHP may disclose this information to any other organization or person as necessary to apply the coordination of benefit rules, without obtaining additional consent from the Member, Subscriber or any other person.

   Each Member claiming benefits under the Agreement must also give NHP any other information it needs to pay claims or to administer benefits under the Agreement. NHP reserves the right to decline coverage for any claim for which it has requested and not received such necessary information.

B. Member must complete NHP Appeal process before Member may bring an action at law or in equity. Such action will not be brought prior to the expiration of 64 days following a final appeal in accordance with requirements of the Agreement. No such action may be brought after the expiration of the applicable statute of limitations. The statute of limitations applicable to any action relative to this appeal will commence from the date services or supplies are rendered giving rise to the action.

C. No interest in the Agreement is assignable without prior written consent of NHP.

D. No person other than a Member is entitled to any benefit under the Agreement.

E. When applying for benefits or services under the Agreement, the Member will present the ID Card provided by NHP.

F. Any notice required or permitted under the Agreement will be deemed given if hand delivered or if mailed by United States Mail, postage prepaid, and addressed as set forth below. Such notice will be deemed effective as of the date delivered or so deposited in the mail.

   1. If to NHP, mailed to the address printed on the Application.

   2. If to a Member, mailed to the most recent address provided by the Member or to the Subscriber's most recent address on file with NHP.

   3. If to Group, mailed to the most recent address provided by the Group to NHP.

G. Unless federal law is applicable, the Agreement will be governed by and construed in accordance with the laws of

the State of Florida and the exclusive and sole venue for any action will be in Miami-Dade County, Florida.

H. The Agreement in writing, together with the Application, the employee enrollment form and any attached endorsement, constitute the entire Agreement between NHP and the Group. No agent of NHP other than a corporate officer of NHP is authorized to establish, change or waive any of the provisions of the Agreement. No change or amendments to the Agreement will be valid unless evidenced by an endorsement, rider or amendment to the Agreement and is signed by an authorized representative of NHP.

I. Time Limit on Certain Defenses. Relative to a misstatement in the Application or employee enrollment form, after two years from the date of issue, only fraudulent misstatements in the Application may be used to void the policy or deny any claim for loss incurred or disability starting after the two year period.

J. Any provision of the Agreement which on its effective date is in conflict with the requirements of statutes or regulations of the jurisdiction in which it is delivered is hereby amended to conform to the minimum requirements of such statutes and regulations.

K. NHP is not responsible for the judgment or conduct of any Network Provider who treats or provides a professional service or supply, but rather each Network Provider is an independent contractor who is not the agent, servant, or employee of NHP. Under the Agreement, NHP makes benefit determinations only relating to Covered Services and does not provide healthcare services or make medical decisions on behalf of Members. Network Providers exercise independent medical judgment on Members' behalf.

L. Members will participate in the development of alternative treatment plans and cooperate with NHP's case management of services they are receiving. In addition to the benefits specified in the Agreement, NHP may provide benefits for services furnished not otherwise covered under the Agreement pursuant to an alternative treatment plan as part of NHP's case management of Member's care. NHP may provide alternative benefit(s) when, in NHP's judgment, alternative services are Medically Necessary, cost effective and feasible and that the total benefits paid for such alternative services do not exceed the total benefits to which Member would otherwise be entitled under the Agreement in the absence of alternative benefits. If NHP elects to provide alternative benefits for a member in one instance, it will not obligate NHP to provide the same or similar benefits for another Member in any other instance, nor will it be construed as a waiver of NHPs right to administer the Agreement thereafter as to the Member receiving alternative benefits in strict compliance with its expressive terms. If benefits under an alternative treatment plan are to be terminated, NHP will provide at least 10 days written notice of the termination to Member.

M. NHP may develop or adopt standards which describe in more detail when NHP will make or will not provide coverage or make payments under the Agreement and administrative rules pertaining to enrollment and other administrative matters. NHP will have all the powers necessary or appropriate to enable NHP to carry out its duties in connection with the administration of the Agreement, including without limitation, the power to conduct utilization review, quality review and case management, the power to construe the Agreement, to determine all questions arising under the Agreement and to make and establish (and therefore change) rules and regulations and procedures with respect to the Agreement. If a Member has a question about the standards which apply to a particular benefit or the administrative rules, Member may contact NHP and NHP will explain the standards or rules.

N. Members may obtain information regarding performance outcomes and financial data for Neighborhood Health Partnership published by the State of Florida Agency for Health Care Administration by accessing the

Neighborhood Health Partnership website, www.myNHP.com. This website includes the link to Florida Health Stat where this information is published or

Members can go directly to www.floridahealthstat.com.

Neighborhood Health Partnership, Inc.

7600 Corporate Center Drive

Miami, FL 33126

1-877-972-8845

Please call Customer Service at 1-877-972-8845 for assistance regarding claims, resolving a complaint or information about Benefits and coverage.

Note: Call Customer Service at the telephone number on your ID card, or check our website www.myNHP.com to determine appropriate providers to contact in the case of an emergency and other information regarding emergency services within the community. In some cases, the most cost effective action may be to visit an Urgent Care Center. Check your Summary of Benefits to determine the copayment or coinsurance for a visit to the Urgent Care Center or your Physician's office, rather than seeking care at an emergency room in a hospital.

Our website www.myNHP.com also includes a health care cost estimator and information regarding plan details, such as copayments and coinsurance for various services, any required deductible and the status of your maximum out-of-pocket.

WARNING: LIMITED BENEFITS WILL BE PAID WHEN NON-NETWORK PROVIDERS ARE USED. You should be aware that when you elect to utilize the services of a non-network provider for a covered service (other than emergency services), benefit payments to the non-network provider are not based upon the amount the non-network provider charges. The basis of the payment will be determined according to the Group Service Agreement's non-network reimbursement benefit. Non-Network providers may bill you for any difference in the amount. YOU MAY BE REQUIRED TO PAY MORE THAN THE COINSURANCE OR COPAYMENT AMOUNT.

The Member Handbook and Summary of Benefits contain a deductible.

Nicholas Zaffiris, CEO

Neighborhood Health Partnership, Inc.

F0UW
20/2500/20%
W/Direct Access Rider

NEIGHBORHOOD HEALTH PARTNERSHIP, Inc.
HMO
SUMMARY OF BENEFITS

A quick glance at this Summary of Benefits will introduce you to the important advantages of Neighborhood Health Partnership, Inc. (NHP).

The Summary of Benefits, although a helpful tool, is only a summary. Always refer to your Handbook for a full explanation of your coverage or call Customer Services at the phone numbers on your health plan ID Card when you have a question about your plan. In the event of a conflict between this Summary of Benefits and the Handbook, the Handbook will control.

Services must be provided by health care providers which have contracts with NHP, referred to as "Network Providers," "Network Physicians" or "Network Hospitals," unless in an Emergency or with prior authorization by NHP.

Features	**Please note: if your Plan has a deductible, the deductible must be satisfied unless otherwise specified. You are also responsible for any deductibles, copayments and/or coinsurance listed below.**
Deductible	$2,500 per member, and/or $5,000 per family, whichever comes first. Individual deductible amounts will count toward the family deductible. However, an individual will not have to pay more than the individual deductible amount. Any deductible is on calendar year basis.
Coinsurance	Benefits as defined below may be subject to a coinsurance of 20% once the calendar year deductible is met.
Out of Pocket Maximum	The limit which you and your eligible family members must pay in copayments and coinsurance per calendar year is $6,350 per member and $12,700 per family. Individual Out of Pocket Maximum amounts will count toward the family Out of Pocket Maximum. However, an individual will not have to pay more than the individual Out of Pocket Maximum amount. Out of Pocket Maximum includes the Deductible.

Primary Care

Your PCP is responsible for coordinating all your health care services, including referrals to Specialists. Your PCP or Physician Specialist must obtain Prior-Authorization for designated services including, but not limited to, all inpatient care, outpatient surgical procedures, durable medical equipment (DME), home health services, home infusion, hospice care, rehabilitation, skilled nursing facility, and transplant services.

Referrals

Your PCP is responsible for coordinating all referrals to specialists, except for the following specialties which you may access directly:

- Podiatry
- Chiropractic
- Dermatology (first 5 visits per year). Additional visits require referrals.
- Gynecology

Note: If your Employer purchased a Direct Access Rider, you may see a Specialist without a referral from your PCP. Please refer to your health plan ID Card or call Customer Service to verify the need to obtain a referral to a Specialist. Even when the Plan includes a Direct Access Rider, you must select a PCP or NHP will assign one to you. If you need assistance, call Customer Service.

YOUR NHP PLAN COVERAGE

IMPORTANT NOTICE:

Unless otherwise stated, care, services or treatment not managed by your Primary Care Physician, not Medically Necessary, or not Prior Authorized by NHP are not Covered Services. Services must be provided by Network Providers, except when Prior Authorized or in the case of an Emergency Medical Condition.

You must check your Handbook for further details relating to your coverage.

Services & Supplies	Your Responsibility for HMO Benefits
Allergy Testing	$20 copayment per visit
Ambulance *(Non-emergency transportation must be authorized in advance by NHP.)*	20% after deductible in emergency situations or when authorized by NHP to transfer you to a NHP facility.
Applied Behavioral Analysis *(Services must be provided by NHP's behavioral health*	***Outpatient*:** $40 copayment per visit ***Inpatient:*** 20% after deductible
Autism Spectrum Disorder	Covered as any other eligible service, based on place of service.
Bones or Joints of the Jaw and Facial Region	Covered as any other eligible service, based on place of service.
Chiropractic Services	$20 copayment per visit Limited to 20 visits per year, PCP referral not required.
Dermatology	$40 copayment per visit PCP referral not required for 5 visits per year; further visits require PCP referral.
Diabetes	$40 copayment per visit Services include outpatient self management training and educational services.
Durable Medical Equipment (DME) and disposable medical supplies, including breast pumps	0% Deductible does not apply
Emergency Room Services	$250 copayment per visit. Any deductible and/or copayment for the emergency room is waived if the patient is admitted to the hospital.
Enteral Formula	20% after deductible
Family Planning	Covered as any other eligible service, based on place of service. Limited to surgical sterilization, implantable contraceptives and intrauterine birth control devices.

Gynecology	$40 copayment per visit PCP referral is not required.

Services & Supplies	Your Responsibility for HMO Benefits
Hearing Aids	20% after deductible Limited to $2,500 per year and to a single purchase (including repair/replacement) every three years.
Hearing Exams *(children through age 19)*	No copayment when performed by PCP to determine need for hearing correction. Limited to one exam per year. Deductible does not apply.
Home Health Services	20% after deductible Limited to 60 visits per year. Custodial care is not covered.
Home Infusion Services	20% after deductible Limited to 60 visits per year.
Hospice Care	20% after deductible
Hospital Facility Care	***Inpatient:*** 20% after deductible ***Outpatient Facility - Surgical Procedures:*** $200 Copayment
Minor Diagnostic/X-Ray and Laboratory Services	0%, deductible does not apply
Major Diagnostic Services, including CT, MRI, MRA, PET Scans and Nuclear Imaging	$250 copayment per service
Mammography Screening	No copayment and not subject to any deductible.
Mastectomy	Covered as any other eligible service, based on place of service.
Maternity Care, including pre- and post-natal care and delivery* Physician Office Services include one OB ultrasound between weeks 13 and 24 of pregnancy.	Covered as any other eligible service, based on place of service. Note: any required office visit copayment applies only to the initial visit.
Mental Health *(Services must be provided by NHP's behavioral health network)*	***Outpatient*:** $40 copayment per visit ***Partial Hospitalization/Intensive Outpatient Treatment:*** 20% after deductible ***Inpatient:*** 20% after deductible

Services & Supplies	Your Responsibility for HMO Benefits
Neurobiological Disorder Services – Autism Spectrum Disorder *(Services must be provided by NHP's behavioral health network)*	***Outpatient*:** $40 copayment per visit ***Partial Hospitalization/Intensive Outpatient Treatment:*** 20% after deductible ***Inpatient:*** 20% after deductible
Newborn Children* (birth – 30 days)	Covered as any other eligible service, based on place of service when enrolled timely.
Organ Transplant Inpatient Services	Covered as any other eligible service, based on place of service. Must be Prior Authorized by NHP Medical Director or designee.
Osteoporosis	Covered as any other eligible service, based on place of service. Limited to diagnosis and treatment of high-risk individuals.
Outpatient Therapies, including Habilitative Services	$20 copayment per visit Outpatient therapies (including Habilitative Services) are limited to 20 visits per year per type of therapy, except 36 visits for cardiac therapy. Pulmonary therapy visits are not limited.
Physical Rehabilitation – Inpatient Care	20% after deductible Limited to 60 days per year for restorative physical therapy.
Physician Services	20% after deductible for inpatient care
Podiatry	$20 copayment per visit PCP referral not required.
Preventive Health Services	No Copayment and not subject to any Deductible.
Primary Care Physician (PCP)	$20 copayment per visit Only applies to your designated PCP.
Prosthetic Devices	20% after deductible
Skilled Nursing Facility	20% after deductible Limited to 120 days per year; custodial care is not covered.
Specialist Office Visits	$40 copayment per visit PCP referral required except as noted above.
Sterilization	Covered as any other eligible service, based on place of service. Reversals are not covered.

Services & Supplies	Your Responsibility for HMO Benefits
Substance Use Disorders *(Services must be provided by NHP's behavioral health network)*	***Outpatient*:** $40 copayment per visit ***Partial Hospitalization/Intensive Outpatient Treatment:*** 20% after deductible ***Inpatient:*** 20% after deductible
Therapeutic Treatments - Outpatient	20% after deductible
Urgent Care Center	$40 copayment per visit
Virtual Visits Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	$10 copayment per visit
Vision Screening *(children through age 19)*	No copayment when performed by PCP. Deductible does not apply.

* For coverage to begin at the date of birth for newborn children, a completed and signed enrollment form must be received by NHP. When received within 30 days of birth; no additional premium will be charged for this 30 day period. When notice is received within 60 days from the date of birth, premium will be charged from the date of birth. If the enrollment form is not received within 60 days of birth, the newborn child will be considered a late enrollee. You must enroll your newborn within these time periods regardless of whether your coverage is family coverage.

Your Handbook has a description of benefits, including any limitations and exclusions.

You have coverage for Prescription Drugs only if your Employer/Group has elected to obtain a Prescription Drug Rider.

7600 Corporate Center Drive, Miami, FL 33126 / PO Box 025680, Miami, FL 33102-5680
www.myUHC.com or call Customer Services at the phone number on your ID Card.

Please call Customer Service at the number on your ID Card for assistance regarding claims, resolving a complaint or information about Benefits and coverage.

Gender Dysphoria Rider

Neighborhood Health Partnership, Inc.

This Rider to the Group Service Agreement ("GSA") is issued to the Employer and provides Benefits for the treatment of Gender Dysphoria.

Because this Rider is part of the GSA, a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in the *Member Handbook (Handbook)* in *ARTICLE I: DEFINITIONS* and in this Rider below.

When we use the words "we," "us," and "our" in this document, we are referring to Neighborhood Health Partnership, Inc. When we use the words "you" and "your," we are referring to people who are Members as the term is defined in the *Handbook* in *ARTICLE I: DEFINTIONS*.

ARTICLE IV: MEDICAL, SURGICAL AND RELATED SERVICES

The following provision is added to the Handbook in ARTICLE IV: MEDICAL, SURGICAL AND RELATED SERVICES:

Gender Dysphoria

Benefits for the treatment of Gender Dysphoria are limited to the following services:

- Psychotherapy for Gender Dysphoria and associated co-morbid psychiatric diagnoses are provided in a Physician's office as described in your *Handbook*.
- Cross-sex hormone therapy:
  - Cross-sex hormone therapy administered by a medical provider (for example during an office visit) is described in your *Handbook*.
  - Cross-sex hormone therapy dispensed from a pharmacy is provided as described in the *Outpatient Prescription Drug Rider.*
  - Puberty suppressing medication is not cross-sex hormone therapy.
- Laboratory testing to monitor the safety of continuous cross-sex hormone therapy.
- Surgery for the treatment of Gender Dysphoria, including the surgeries listed below.

  Male to Female:

  - Clitoroplasty (creation of clitoris)
  - Labiaplasty (creation of labia)
  - Orchiectomy (removal of testicles)
  - Penectomy (removal of penis)
  - Urethroplasty (reconstruction of female urethra)
  - Vaginoplasty (creation of vagina)

  Female to Male:

  - Bilateral mastectomy or breast reduction
  - Hysterectomy (removal of uterus)
  - Metoidioplasty (creation of penis, using clitoris)
  - Penile prosthesis
  - Phalloplasty (creation of penis)

- Salpingo-oophorectomy (removal of fallopian tubes and ovaries)
- Scrotoplasty (creation of scrotum)
- Testicular prosthesis
- Urethroplasty (reconstruction of male urethra)

- Vaginectomy (removal of vagina)
- Vulvectomy (removal of vulva)

Genital Surgery and Bilateral Mastectomy or Breast Reduction Surgery Documentation Requirements:

The Member must provide documentation of the following for breast surgery:

- A written psychological assessment from at least one qualified behavioral health provider experienced in treating Gender Dysphoria. The assessment must document that the Member meets all of the following criteria:
  - Persistent, well-documented Gender Dysphoria.
  - Capacity to make a fully informed decision and to consent for treatment.
  - Must be 18 years or older.
  - If significant medical or mental health concerns are present, they must be reasonably well controlled.

The Member must provide documentation of the following for genital surgery:

- A written psychological assessment from at least two qualified behavioral health providers experienced in treating Gender Dysphoria, who have independently assessed the Member. The assessment must document that the Member meets all of the following criteria.
  - Persistent, well-documented Gender Dysphoria.
  - Capacity to make a fully informed decision and to consent for treatment.
  - Must 18 years or older.
  - If significant medical or mental health concerns are present, they must be reasonably well controlled.
  - Complete at least 12 months of successful continuous full-time real-life experience in the desired gender.
  - Complete 12 months of continuous cross-sex hormone therapy appropriate for the desired gender (unless medically contraindicated).

Summary of Benefits

The provision below for Gender Dysphoria is added to the Summary of Benefits.

Covered Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Gender Dysphoria			
	Depending upon where the Covered Service is provided, Benefits will be the same as those stated under each Covered Service category in the *Summary of Benefits* and in the *Outpatient Prescription Drug Rider.*		

ARTICLE VI: EXCLUSIONS AND LIMITATIONS

The following exclusion is added to the Handbook under ARTICLE VI: EXCLUSIONS AND LIMITATIONS:

Cosmetic Procedures, including the following Abdominoplasty, Blepharoplasty, Breast enlargement, including augmentation mammoplasty and breast implants, Body contouring, such as lipoplasty, Brow lift, Calf implants, Cheek, chin, and nose implants, Injection of fillers or neurotoxins, Face

lift, forehead lift, or neck tightening, Facial bone remodeling for facial feminizations, Hair removal, Hair transplantation, Lip augmentation, Lip reduction, Liposuction, Mastopexy, Pectoral implants for chest masculinization, Rhinoplasty, Skin resurfacing, Thyroid cartilage reduction; reduction thyroid chondroplasty; trachea shave (removal or reduction of the Adam's Apple), Voice modification surgery and Voice lessons and voice therapy.

ARTICLE I: DEFINITIONS

The following definition of Gender Dysphoria is added to the Handbook under ARTICLE I: DEFINITIONS:

Gender Dysphoria - a disorder characterized by the following diagnostic criteria classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association:*

- *Diagnostic criteria for adults and adolescents:*
  - A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by at least two of the following:
    - A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).
    - A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
    - A strong desire for the primary and/or secondary sex characteristics of the other gender.
    - A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
    - A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
    - A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).
  - The condition is associated with clinically significant distress or impairment in social, occupational or other important areas of functioning.
- *Diagnostic criteria for children:*
  - A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by at least six of the following (one of which must be criterion as shown in the first bullet below):
    - A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender).
    - In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing.
    - A strong preference for cross-gender roles in make-believe play or fantasy play.
    - A strong preference for the toys, games or activities stereotypically used or engaged in by the other gender.
    - A strong preference for playmates of the other gender.
    - In boys (assigned gender), a strong rejection of typically masculine toys, games and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games and activities.
    - A strong dislike of ones' sexual anatomy.
    - A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.
  - The condition is associated with clinically significant distress or impairment in social, school or other important areas of functioning.

Please call Customer Service at the telephone number on your ID card for assistance regarding claims, resolving a complaint or information about Benefits and coverage. Our website www.myuhc.com also includes a health care cost estimator and information regarding plan details, such as copayments and coinsurance for various services, any required deductible and the status of your maximum out-of-pocket.

Nicholas Zaffiris, CEO

Neighborhood Health Partnership, Inc.

UnitedHealthcare
Neighborhood Health Partnership

DIRECT ACCESS RIDER

As of the Effective Date, and notwithstanding anything in the Group Service Agreement ("Agreement") to the contrary, the following Direct Access Rider is hereby made a part of the Agreement if elected by the Group and such election is evidenced in the Group's Application for Group Service Agreement. The terms used in this Rider shall have the same meaning ascribed thereto or used in the Agreement, unless otherwise stated herein.

DIRECT ACCESS PROGRAM

A Member with a Direct Access Rider has the right to elect to visit an NHP Specialist without a referral from the Primary Care Physician or Plan ("Direct Access Visit(s)"). Direct Access Visits are subject to the terms and conditions of the Agreement and this Direct Access Rider. All services and treatment rendered to the Member by a NHP Specialist during or in connection with a Direct Access Visit are subject to NHP's Utilization Review (UR) requirements and the Agreement, except as may be stated otherwise in this Rider. A Direct Access Visit includes services and treatment received from an NHP Specialist, so long as such services do not require pre-certification from NHP. Those services which require pre-certification under the Plan's UR requirements require pre-certification on a Direct Access Visit.

NEIGHBORHOOD HEALTH PARTNERSHIP, INC.

Nicholas J. Zaffiris
CEO
South Florida Health Plans

Outpatient Prescription Drug Rider

Neighborhood Health Partnership, Inc.

Table of Contents

Outpatient Prescription Drug Rider

This Rider to the Group Service Agreement (GSA) and its Member Handbook is issued to the Enrolling Group and provides Benefits for outpatient Prescription Drug Products.

Benefits are provided only when the Prescription Order or Refill has been issued by a Network Physician or other Network provider.

Benefits are provided for outpatient Prescription Drug Products at a Network Pharmacy.

Because this Rider is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in (Section 3: Glossary of Defined Terms) of this Rider.

Nicholas Zaffiris, CEO

Neighborhood Health Partnership, Inc.

When we use the words "we," "us," and "our" in this document, we are referring to Neighborhood Health Partnership, Inc. (NHP). When we use the words "you" and "your" we are referring to people who are Covered Persons as the term is defined in your Member Handbook.

NOTE: The Coordination of Benefits provision in your Member Handbook does not apply to Prescription Drug Products covered through this Rider. Prescription Drug Product Benefits will not be coordinated with those of any other health coverage plan.

Please call *Customer Care* at the telephone number on your ID card for assistance regarding claims, resolving a complaint or information about Benefits and coverage.

Introduction

Benefits for Outpatient Prescription Drug Products

Benefits are available for Outpatient Prescription Drug Products on our Prescription Drug List at a Network Pharmacy and are subject to Copayments or other payments that vary depending on which of the tiers of the Prescription Drug List the Outpatient Prescription Drug is listed.

Coverage Policies and Guidelines

Our Pharmaceutical Product List ("PDL") Management Committee is authorized to make tier placement changes on our behalf. The PDL Management Committee makes the final classification of an *FDA*-approved Prescription Drug Product to a certain tier by considering a number of factors including clinical and economic factors. Clinical factors may include evaluations of the place in therapy, relative safety or relative efficacy of the Prescription Drug Product, as well as whether supply limits or notification requirements should apply. Economic factors may include the Prescription Drug Product's acquisition cost including available rebates, and assessments on the cost effectiveness of the Prescription Drug Product.

We may periodically change the placement of a Prescription Drug Product among the tiers. These changes generally will occur quarterly, but no more than six times per calendar year. These changes may occur without prior notice to you. Some Prescription Drug Products are more cost effective for specific indications as compared to others; therefore, a Prescription Drug Product may be listed on multiple tiers according to the indication for which the Prescription Drug Product was prescribed.

When considering a Prescription Drug Product for tier placement, the PDL Management Committee reviews clinical and economic factors regarding Covered Persons as a general population. Whether a particular Prescription Drug Product is appropriate for an individual Covered Person is a determination that is made by the Covered Person and the prescribing Physician.

NOTE: The tier status of a Prescription Drug Product may change periodically based on the process described above. As a result of such changes, you may be required to pay more or less for that Prescription Drug Product. Please access www.myNHP.com through the Internet, or call the Customer Service number on your ID card for the most up-to-date tier status.

Identification Card (ID Card) - Network Pharmacy

You must either show your ID card at the time you obtain your Prescription Drug Product at a Network Pharmacy or you must provide the Network Pharmacy with identifying information that can be verified by us during regular business hours.

If you don't show your ID card or provide verifiable information at a Network Pharmacy, you will be required to pay the Usual and Customary Charge for the Prescription Drug Product at the pharmacy.

You may seek reimbursement from us as described in your Member Handbook. When you submit a claim on this basis, you may pay more because you failed to verify your eligibility when the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Copayment and/or Coinsurance, and any deductible that applies. **Please note** that your prescription drug summary of benefits will indicate if your Benefits are subject to the medical deductible.

Designated Pharmacies

If you require certain Prescription Drug Products, including Specialty Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those

Prescription Drug Products. If you choose not to obtain your Prescription Drug Product from the Designated Pharmacy, you may opt-out of the programs through the Internet at www.myNHP.com or by calling *Customer Care* at the telephone number of your ID card. If you want to opt-out of a program and fill your Prescription Drug Product at a nondesignated pharmacy but do not inform us, you will be responsible for the entire cost of the Prescription Drug Product.

In this case, Benefits will only be paid if your Prescription Order or Refill is obtained from the Designated Pharmacy.

Limitation on Selection of Pharmacies

If we determine that you may be using Prescription Drug Products in a harmful or abusive manner, or with harmful frequency, your selection of Network Pharmacies may be limited. If this happens, we may require you to select a single Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if you use the designated single Network Pharmacy. If you don't make a selection within 31 days of the date we notify you, we will select a single Network Pharmacy for you.

Rebates and Other Payments to Us

We may receive rebates for certain drugs included on our Prescription Drug List. We do not consider these rebates in calculating any percentage Copayments. We are not required to pass on to you, and we do not pass on to you, amounts payable to us under rebate programs or other such discounts.

We, and a number of our affiliated entities, conduct business with various pharmaceutical manufacturers separate and apart from this Outpatient Prescription Drug Rider. Such business may include data collection, consulting, educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this Outpatient Prescription Drug Rider. We are not required to pass on to you, and we do not pass on to you, such amounts.

Coupons, Incentives and Other Communications

At various times, we may send mailings or provide other communications to you, your Physician, or your pharmacy that communicate a variety of messages, including information about Prescription and non-prescription Drug Products. These communications may include offers that enable you, at your discretion, to purchase the described product at a discount. In some instances, non-NHP entities may support and/or provide content for these communications and offers. Only you and your Physician can determine whether a change in your Prescription and/or non-prescription Drug regimen is appropriate for your medical condition.

We may not permit certain coupons or offers from pharmaceutical manufacturers to apply to your Out-of-Pocket Drug Maximum. You may access information on which coupons or offers are not permitted through the Internet at www.myNHP.com or by calling *Customer Care* at the telephone number on your ID card.

Maintenance Medication Program

If you require certain Maintenance Medications, we may direct you to the Mail Order Network Pharmacy to obtain those Maintenance Medications. If you choose not to obtain your Maintenance Medications from the Mail Order Network Pharmacy, you may opt-out of the Maintenance Medication Program through the Internet at www.myNHP.com or by calling *Customer Care* at the telephone number on your ID card. If you choose to opt out of Mail Order Network Pharmacy but do not inform us, you will be subject to the non-Network Benefit for that Prescription Drug Product after the allowed number of fills at Retail Network Pharmacy.

Special Programs

We may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access

information on these programs through the Internet at www.myNHP.com or by calling *Customer Care* at the telephone number on your ID card.

Smart Fill Program - Split Fill

Certain Specialty Prescription Drug Products may be dispensed by the Designated Pharmacy in 15-day supplies up to 90 days and at a pro-rated Copayment or Coinsurance. You will receive a 15-day supply of their Specialty Prescription Drug Product to determine if you will tolerate the Specialty Prescription Drug Product prior to purchasing a full supply. The Designated Pharmacy will contact you each time prior to dispensing the 15-day supply to confirm if you are tolerating the Specialty Prescription Drug Product. You may find a list of Specialty Prescription Drug Products included in the *Split Fill Program*, through the Internet at www.myNHP.com or by calling *Customer Care* at the telephone number on your ID card.

Smart Fill Program - 90 Day Supply

Certain Specialty Prescription Drug Products may be dispensed by the Designated Pharmacy in 90-day supplies. The Copayment and/or Coinsurance will reflect the number of days dispensed. The *Smart Fill Program* which offers a 90 day supply of certain Specialty Prescription Drug Products is for a Covered Person who is stabilized on a Specialty Prescription Drug Product included in the *Smart Fill Program*. You may find a list of Specialty Prescription Drug Products included in the *Smart Fill Program*, through the Internet www.myNHP.com or by calling *Customer Care* at the telephone number on your ID card.

Step Therapy

Certain Prescription Drug Products for which Benefits are described under this Outpatient Prescription Drug Rider are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products, you are required to use a different Prescription Drug Product(s) first.

You may determine whether a particular Prescription Drug Product is subject to step therapy requirements through the Internet at www.myNHP.com or by calling *Customer Service* at the telephone number on your ID card.

Prescription Drug Products Prescribed by a Specialist Physician

You may receive an enhanced or reduced Benefit, or no Benefit, based on whether the Prescription Drug Product was prescribed by a Specialist Physician. You may access information on which Prescription Drug Products are subject to Benefit enhancement, reduction or no Benefit through the Internet at www.myNHP.com or by calling *Customer Care* at the telephone number on your ID card.

Section 1: What's Covered--Prescription Drug Benefits

We provide Benefits under the GSA for outpatient Prescription Drug Products:

- Designated as covered at the time the Prescription Order or Refill is dispensed when obtained from a Network Pharmacy.
- Refer to exclusions in your Member Handbook and those listed in Section 2 of this Rider.

Utilization Review

Drug utilization review and clinical review programs are used to monitor the dosage and treatment patterns for Members covered under this Rider. Under these programs, NHP may limit or otherwise restrict the quantity or type of drug for which we will provide a benefit based upon the cost of the drug prescribed by your Provider, clinical indications and other factors. Drugs that are subject to utilization review programs are not Covered Prescription Drugs unless the requirements of our utilization review and/or clinical programs, and all of the other terms and conditions described in this Rider are met. Drugs that are subject to utilization review and clinical review programs always require NHP's prior authorization before they will be covered. The list of drugs that require prior authorization may be amended by NHP from time to time.

Benefits for Outpatient Prescription Drug Products

Benefits for outpatient Prescription Drug Products are available when the outpatient Prescription Drug Product meets the definition of a Covered Health Service or is prescribed to prevent conception.

Benefits for Oral Chemotherapy Cancer Medications

Oral chemotherapeutic agent Prescription Drug Products will be provided at a level no less favorable than chemotherapeutic agents are provided under Pharmaceutical Products - Outpatient in your Handbook, regardless of tier placement.

When a Brand-name Drug Becomes Available as a Generic

When a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change, and therefore your Copayment and/or Coinsurance may change. You will pay the Copayment and/or Coinsurance applicable for the tier to which the Prescription Drug Product is assigned.

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change, and therefore your Copayment and/or Coinsurance may change or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.

Benefits are provided only when the Prescription Order or Refill has been issued by a Network Physician or other Network provider.

Supply Limits

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description of Pharmacy Type and Supply Limits" column of the Benefit Information table. For a single Copayment, you may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that we have developed, subject to our periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply.

You may determine whether a Prescription Drug Product has been assigned a maximum quantity level for dispensing through the Internet at www.myNHP.com or by calling Customer Service at the telephone number on your ID card.

Notification Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician, your pharmacist or you are required to obtain prior authorization from us or our designee. The reason for obtaining prior authorization from us is to determine whether the Prescription Drug Product, in accordance with our approved guidelines, is each of the following:

- It meets the definition of a Covered Health Service.
- It is not Experimental, Investigational or Unproven.

Network Pharmacy Notification

When Prescription Drug Products are dispensed at a Network Pharmacy, the prescribing provider, the pharmacist, or you are responsible for notifying us.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you may pay more for that Prescription Order or Refill. The Prescription Drug Products requiring prior authorization are subject to our periodic review and modification. There may be certain Prescription Drug Products that require you to notify us directly rather than your Physician or pharmacist. You may determine whether a particular Prescription Drug Product requires prior authorization through the Internet at www.myNHP.com or by calling *Customer Care* at the telephone number on your ID card.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Copayment and/or Coinsurance and any deductible that applies.

When you submit a claim on this basis, you may pay more because you did not notify us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Copayment and any deductible that applies.

Please note that your prescription drug summary of benefits will indicate if your Benefits are subject to the medical deductible.

Benefits may not be available for the Prescription Drug Product after we review the documentation provided and we determine that the Prescription Drug Product is not a Covered Health Service or it is Experimental, Investigational or Unproven.

What You Must Pay

You are responsible for paying the applicable Copayment described in the Benefit Information table when Prescription Drug Products are obtained from a retail or mail order pharmacy.

You are responsible for paying the applicable Copayment and/or Coinsurance described in the Benefit Information table. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

The amount you pay for any of the following under this Rider will not be included in calculating any **Out-of-Pocket Maximum stated in your Member Handbook and its Summary of Benefits**:

- When you choose the higher tiered drug of the two, you will pay the difference between the higher tiered drug and the lower tiered drug in addition to your Copayment and/or Coinsurance that applies to the lower tiered drug.
- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for

any non-covered drug product and our contracted rates (our Prescription Drug Charge) will not be available to you.

Payment Information

Copayment

Copayments for a Prescription Drug Product at a Network Pharmacy can be either a specific dollar amount or a percentage of the Prescription Drug Charge.

Your Copayment is determined by the tier to which the Pharmaceutical Product List Management Committee has assigned a Prescription Drug Product.

NOTE: The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Pharmaceutical Product List Management Committee's periodic tiering decisions. When that occurs, your Copayment may change. Please access www.myNHP.com through the Internet, or call the Customer Service number on your ID card for the most up-to-date tier status.

For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lowest of the following:

- The applicable Copayment and/or Coinsurance.
- The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product.
- The Prescription Drug Charge for that Prescription Drug Product.

For Prescription Drug Products from a mail order delivery Network Pharmacy, you are responsible for paying the lower of:

- The applicable Copayment or
- The Prescription Drug Charge for that Prescription Drug Product.

Benefit Information

Description of Pharmacy Type and Supply Limits	Your Copayment Amount
Prescription Drugs from a Retail Network Pharmacy	
Benefits are provided for outpatient Prescription Drug Products dispensed by a retail Network Pharmacy. The following supply limits apply: • As written by the provider, up to a consecutive 30-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or	**Your Copayment is determined by the tier to which the Pharmaceutical Product List Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products, other than Preventive Care Medications, on the Prescription Drug List are assigned to Tier-1, Tier-2, or Tier-3. Please access www.myNHP.com through the Internet, or call the Customer Service number on your ID card to determine tier status.** $20 of the Prescription Drug Charge per Prescription Order or Refill for a **Tier-**

Description of Pharmacy Type and Supply Limits	Your Copayment Amount
based on supply limits. • A one-cycle supply of an oral contraceptive. You may obtain up to three cycles at one time if you pay a Copayment for each cycle supplied. **Note: Preventive Care Medications are payable as defined in (Section 3: Glossary of Defined Terms) of this Rider. Such medications are not assigned to any specific tier.**	**1 Prescription Drug Product**. $20 of the Prescription Drug Charge per Prescription Order or Refill for a **Tier-1 Specialty Prescription Drug Product**. $40 of the Prescription Drug Charge per Prescription Order or Refill for a **Tier-2 Prescription Drug Product**. $125 of the Prescription Drug Charge per Prescription Order or Refill for a **Tier-2 Specialty Prescription Drug Product**. $60 of the Prescription Drug Charge per Prescription Order or Refill for a **Tier-3 Prescription Drug Product**. $250 of the Prescription Drug Charge per Prescription Order or Refill for a **Tier-3 Specialty Prescription Drug Product**. **For growth hormone therapy**, 30% of the Prescription Drug Charge.
Prescription Drug Products from a Mail Order Network Pharmacy Benefits are provided for outpatient Prescription Drug Products dispensed by a home delivery Network Pharmacy. The following supply limits apply: • As written by the provider, up to a consecutive 90-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate. You will be charged a mail order Copayment for any Prescription Orders or Refills sent to the mail order pharmacy regardless of the number-of-days' supply written on the Prescription Order or Refill. Be sure your Physician writes your Prescription Order or refill for a 90-day supply, not a 30-day supply with three refills.	**Your Copayment is determined by the tier to which the Pharmaceutical Product List Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier-1, Tier-2, or Tier-3. Please access www.myNHP.com through the Internet, or call the Customer Service number on your ID card to determine tier status.** **For up to a 90-day supply, your Copayment is:** $40 of the Prescription Drug Charge per Prescription Order or Refill for a **Tier-1 Prescription Drug Product**. $80 of the Prescription Drug Charge per Prescription Order or Refill for a **Tier-2 Prescription Drug Product**. $120 of the Prescription Drug Charge per Prescription Order or Refill for a **Tier-3 Prescription Drug Product**.

Description of Pharmacy Type and Supply Limits	Your Copayment Amount
	For growth hormone therapy, 30% of the Prescription Drug Charge.

Section 2: What's Not Covered - Exclusions

Exclusions from coverage listed in your Member Handbook apply also to this Rider. In addition, the following exclusions apply:

1. Outpatient Prescription Drug Products obtained from a non-Network Pharmacy.
2. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
3. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
4. Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.
5. Drugs which are prescribed, dispensed or intended for use while you are an inpatient in a Hospital, Skilled Nursing Facility, or Alternate Facility.
6. Experimental, Investigational or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by us to be experimental, investigational or unproven.
7. Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided from the local, state or federal government (for example, Medicare).
8. Prescription Drug Products for any condition, Injury, Sickness or mental illness arising out of, or in the course of, employment for which benefits are paid under any workers' compensation law or other similar laws.
9. Any product dispensed for the purpose of appetite suppression and other weight loss products.
10. A Prescription Drug Product (including immunizations and allergy serum) which, due to is characteristics as determined by us, must typically be administered or supervised by a qualified provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.
11. Durable Medical Equipment, including insulin pumps and related supplies for the management and treatment of diabetes, for which Benefits are provided in your Handbook. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.
12. General vitamins, except the following which require a Prescription Order or Refill: prenatal vitamins, vitamins with fluoride, and single entity vitamins.
13. Unit dose packaging of Prescription Drug Products.
14. Medications used for cosmetic purposes.
15. Prescription Drug Products, including New Prescription Drug Products or new dosage forms that are determined to not be a Covered Health Service.
16. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
17. Prescription Drug Products when prescribed to treat infertility.
18. Treatment for toenail Onychomycosis/toenail fungus.
19. Certain Prescription Drug Products for smoking cessation.
20. Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration (FDA) and requires a Prescription Order or Refill. Compounded drugs that contain a non-FDA approved

bulk chemical. Compounded drugs that are available as a similar commercially available Prescription Drug Product. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier 3.)

21. Drugs available over the counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless we have designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that we have determined are therapeutically equivalent to an over-the-counter drug or supplement. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

22. Certain new Prescription Drug Products and/or new dosage forms until the date they are reviewed and assigned to a tier by our Pharmaceutical Product List Management Committee.

23. A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

24. A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

25. Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).

26. Any medication that is used for treatment of erectile dysfunction, sexual dysfunction, or sexual enhancement.

27. Certain Prescription Drug Products that have not been prescribed by a Specialist Physician.

28. A Prescription Drug Product that contains marijuana, including medical marijuana.

29. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Sickness or Injury.

30. Any product designed to adjust sleep schedules, such as for jet lag or shift work.

31. Dental products, including prescription fluoride topicals.

32. A Prescription Drug Product with an approved biosimilar or a biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product. For the purpose of this exclusion a "biosimilar" is a biological Prescription Drug Product approved based on showing that it is highly similar to a reference product (a biological Prescription Drug Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

33. Prescription Drug Products when prescribed as sleep aids.

34. Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.

35. Diagnostic kits and products.

36. Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives available, unless

otherwise required by law or approved by us. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

Section 3: Glossary of Defined Terms

This section:

- Defines the terms used throughout this Rider. Other defined terms used throughout this Rider can be found in your Member Handbook.
- Is not intended to describe Benefits.

Biosimilar - A biological Prescription Drug Product approved based on showing that it is highly similar to a Reference Product, and has no clinically meaningful differences in terms of safety and effectiveness from the Reference Product.

Brand-name - a Prescription Drug Product: (1) which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that we identify as a Brand-name product, based on available data resources including First DataBank and/or MediSpan, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "brand name" by the manufacturer, pharmacy, or your Physician may not be classified as Brand-name by us.

Chemically Equivalent - when Prescription Drug Products contain the same active ingredient.

Coinsurance - the charge, stated as a percentage of Eligible Expenses, that you are required to pay for certain Covered Services. For Pharmaceutical Products, your Coinsurance is determined by the tier to which the Pharmaceutical Product List Management Committee has assigned the Pharmaceutical Product, and will vary based upon the tier assignment.

Copayment - means the charge, states as a set dollar amount, that you are required to pay for certain Covered Services. For Pharmaceutical Products, your Copayment is determined by the tier to which the Pharmaceutical Product List Management Committee has assigned the Pharmaceutical Product, and will vary based upon the tier assignment.

Designated Pharmacy - a pharmacy that has entered into an agreement on behalf of the pharmacy with us or with an organization contracting on our behalf, to provide specific Prescription Drug Products. The fact that a pharmacy is a Network Pharmacy does not mean that it is a Designated Pharmacy.

Generic - a Prescription Drug Product: (1) that is chemically equivalent to a Brand-name drug; or (2) that we identify as a Generic product based on available data resources including First DataBank and/or MediSpan, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "generic" by the manufacturer, pharmacy or your Physician may not be classified as a Generic by us.

Maintenance Medication - a Prescription Drug Product anticipated to be used for six months or more to treat or prevent a chronic condition. You may determine whether a Prescription Drug Product is a Maintenance Medication through the Internet at www.myNHP.com or by calling *Customer Care* at the telephone number on your ID card.

Maximum Allowable Cost (MAC) List - a list of Generic Prescription Drug Products that will be covered at a price level that we establish. This list is subject to our periodic review and modification.

Network Pharmacy - a pharmacy that has:

- Entered into an agreement with us or our designee to provide Prescription Drug Products to Covered Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- Been designated by us as a Network Pharmacy.

A Network Pharmacy can be either a retail or a mail order pharmacy.

New Prescription Drug Product - a Prescription Drug Product or new dosage form of a previously approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or new dosage form is approved by the *FDA*, and ending on the earlier of the following dates:

- The date it is assigned to a tier by our Pharmaceutical Product List Management Committee.
- December 31st of the following calendar year.

Non-Preferred Specialty Network Pharmacy - a specialty pharmacy that we identify as a non-preferred pharmacy within the Network.

Pharmaceutical Product List Management Committee - the committee that we designate for, among other responsibilities, classifying Prescription Drug Products into specific tiers.

Prescription Drug Charge - the rate we have agreed to pay our Network Pharmacies, including a dispensing fee and any sales tax, for a Prescription Drug Product dispensed at a Network Pharmacy.

Prescription Drug List - a list that identifies those Prescription Drug Products for which Benefits are available under this Rider. This list is subject to our periodic review and modification (generally quarterly, but no more than six times per calendar year). You may determine to which tier a particular Prescription Drug Product has been assigned through the Internet at www.myNHP.com or by calling the Customer Service number on your ID card.

Prescription Drug Product - a medication or product that has been approved by the Food and Drug Administration and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. A Prescription Drug Product includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For the purpose of Benefits under the GSA, this definition includes:

- Inhalers (with spacers).
- Insulin.
- The following diabetic supplies:
  - standard insulin syringes with needles;
  - blood-testing strips - glucose;
  - urine-testing strips - glucose;
  - ketone-testing strips and tablets;
  - lancets and lancet devices;
  - glucose monitors.

Prescription Order or Refill - the directive to dispense a Prescription Drug Product issued by a duly licensed health care provider whose scope of practice permits issuing such a directive.

Preventive Care Medications - the medications that are obtained at a Network Pharmacy with a Prescription Order or Refill from a Physician and that are payable at 100% of the Prescription Drug Charge (without application of any Copayment, Coinsurance or Annual Deductible) as required by applicable law under any of the following:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*.
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.

You may determine whether a drug is a Preventive Care Medication through the Internet at www.myNHP.com or by calling *Customer Care* at the telephone number on your ID card.

Reference Product - A biological Prescription Drug Product.

Specialty Prescription Drug Product - Prescription Drug Products that are generally high cost, self-administered biotechnology drugs used to treat patients with certain illnesses. Specialty Prescription Drug Products may include drugs on the List of Preventive Medications. You may access a complete list of Specialty Prescription Drug Products through the Internet at www.myNHP.com or by calling *Customer Care* at the telephone number on your ID card.

Therapeutically Equivalent - when Prescription Drug Products have essentially the same efficacy and adverse effect profile.

Usual and Customary Charge - the usual fee that a pharmacy charges individuals for a Prescription Drug Product without reference to reimbursement to the pharmacy by third parties.

Real Appeal Rider

Neighborhood Health Partnership, Inc.

This Rider to the Group Service Agreement and the Member Handbook provides Covered Services for virtual obesity counseling services for eligible Members through Real Appeal. There are no deductibles, Copayments or Coinsurance you must meet or pay for when receiving these services.

Real Appeal

Covered Services are provided for Real Appeal, which provides a virtual lifestyle intervention for weight-related conditions to eligible Members. The goal is to help those at risk from obesity-related diseases. Real Appeal is designed to support Members 18 years of age or older.

This intensive, multi-component behavioral intervention provides 52 weeks of support. This support includes one-on-one coaching and online group participation with supporting video content, delivered by a live virtual coach. The experience will be personalized for each individual through an introductory online session.

These Covered Services will be individualized and may include the following:

- Virtual support and self-help tools: Personal one-on-one coaching, group support sessions, educational videos, tailored kits, integrated web platform and mobile applications.
- Education and training materials focused on goal setting, problem-solving skills, barriers and strategies to maintain changes.
- Behavioral change counseling by a specially trained coach for clinical weight loss.

If you would like additional information regarding these Covered Services, you may contact us through www.realappeal.com, https://member.realappeal.com or *Customer Service* at the number shown on your ID card.

Please call *Customer Service* at the telephone number on your ID Card for assistance regarding claims, resolving a complaint or information about Covered Services and coverage.

Nicholas Zaffiris, CEO

Neighborhood Health Partnership, Inc.

Language Assistance Services

We[1] provide free language services. We provide free services to help you communicate with us. Such as, letters in others languages or large print. Or, you can ask for an interpreter. To ask for help, please call 1-866-633-2446, or the toll-free member phone number listed on your health plan ID card TTY 711, Monday through Friday, 8 a.m. to 8 p.m. ET.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Please call 1-866-633-2446.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al 1-866-633-2446.

請注意：如果您說中文 **(Chinese)**，我們免費為您提供語言協助服務。請致電：1-866-633-2446。

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi 1-866-633-2446.

알림: 한국어**(Korean)**를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-633-2446 번으로 전화하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Mangyaring tumawag sa 1-866-633-2446.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русском (Russian)**. Позвоните по номеру 1-866-633-2446.

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الأتصال بـ 1-866-633-2446

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nan 1-866-633-2446.

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le 1-866-633-2446.

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod numer 1-866-633-2446.

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue para 1-866-633-2446.

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Si prega di chiamare il numero 1-866-633-2446.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufen Sie 1-866-633-2446 an.

注意事項：**日本語 (Japanese)** を話される場合、無料の言語支援サービスをご利用いただけます。1-866-633-2446 にお電話ください。

توجه: اگر زبان شما **فارسی (Farsi)** است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد.
1-866-633-2446 تماس بگیرید.

कृपा ध्यान दें: यदि आप **हिंदी (Hindi)** भाषी हैं तो आपके लिए भाषा सहायता सेवाएं नि:शुल्क उपलब्ध हैं। कृपा पर काल करें 1-866-633-2446

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau 1-866-633-2446.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយ**ភាសាខ្មែរ(Khmer)**សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទ ទៅលេខ 1-866-633-2446។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti 1-866-633-2446.

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shoodí kohjį' 1-866-633-2446 hodíilnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac 1-866-633-2446.

Notice of Non-Discrimination

We[1] do not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to:

Civil Rights Coordinator

United HealthCare Civil Rights Grievance

P.O. Box 30608

Salt Lake City, UTAH 84130

UHC_Civil_Rights@uhc.com

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.

If you need help with your complaint, please call 1-866-633-2446 or the toll-free member phone number listed on your health plan ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human services.

Online https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

[1]For purposes of the Language Assistance Services and this Non-Discrimination Notice ("Notice"), "we" refers to the entities listed in Footnote 2 of the Notice of Privacy Practices and Footnote 3 of the Financial Information Privacy Notice. Please note that not all entities listed are covered by this Notice.

Important Notices under the Patient Protection and Affordable Care Act (PPACA)

Changes in Federal Law that Impact Benefits

There are changes in Federal law which may impact coverage and Benefits stated in the *Member Handbook* and *Summary of Benefits*. A summary of those changes and the dates the changes are effective appear below. These changes will apply to any "non-grandfathered" plan. Contact your Plan Administrator to determine whether or not your plan is a "grandfathered" or a "non-grandfathered plan". Under the *Patient Protection and Affordable Care Act (PPACA)* a plan generally is "grandfathered" if it was in effect on March 23, 2010 and there are no substantial changes in the benefit design as described in the *Interim Final Rule on Grandfathered Health Plans* at that time.

Patient Protection and Affordable Care Act (PPACA)

Effective for policies that are new or renewing on or after September 23, 2010, the requirements listed below apply.

- Lifetime limits on the dollar amount of essential benefits available to you under the terms of your plan are no longer permitted. Essential benefits include the following:

  Ambulatory patient services; emergency services, hospitalization; laboratory services; maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment); prescription drugs; rehabilitative and habilitative services and devices; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

- On or before the first day of the first plan year beginning on or after September 23, 2010, the enrolling group will provide a 30 day enrollment period for those individuals who are still eligible under the plan's eligibility terms but whose coverage ended by reason of reaching a lifetime limit on the dollar value of all benefits.

- Essential benefits for plan years beginning prior to January 1, 2014 can only be subject to restricted annual limits. Restricted annual limits for each person covered under the plan may be no less than the following:

  - For plan or policy years beginning on or after September 23, 2010 but before September 23, 2011, $750,000.
  - For plan or policy years beginning on or after September 23, 2011 but before September 23, 2012, $1,250,000.
  - For plan or policy years beginning on or after September 23, 2012 but before January 1, 2014, $2,000,000.

  Please note that for plan years beginning on or after January 1, 2014, essential health benefits cannot be subject to annual or lifetime dollar limits.

- Coverage for enrolled dependent children is no longer conditioned upon full-time student status or other dependency requirements and will remain in place until the child's 26th birthday. If you have a grandfathered plan, the enrolling group is not required to extend coverage to age 26 if the child is eligible to enroll in an eligible employer-sponsored health plan (as defined by law).

  On or before the first day of the first plan year beginning on or after September 23, 2010, the enrolling group will provide a 30 day dependent child special open enrollment period for dependent children who are not currently enrolled under the policy and who have not yet reached age 26.

During this dependent child special open enrollment period, subscribers who are adding a dependent child and who have a choice of coverage options will be allowed to change options.

- If your plan includes coverage for enrolled dependent children beyond the age of 26, which is conditioned upon full-time student status, the following applies:

  Coverage for enrolled dependent children who are required to maintain full-time student status in order to continue eligibility under the policy is subject to the statute known as *Michelle's Law*. This law amends *ERISA*, the *Public Health Service Act*, and the *Internal Revenue Code* and requires group health plans, which provide coverage for dependent children who are post-secondary school students, to continue such coverage if the student loses the required student status because he or she must take a medically necessary leave of absence from studies due to a serious illness or Injury.

- If you do not have a grandfathered plan, benefits for preventive care services described below will be paid at 100%, and not subject to any deductible, coinsurance or copayment. If you have pharmacy benefit coverage, your plan may also be required to cover preventive care medications that are obtained at a network pharmacy at 100%, and not subject to any deductible, coinsurance or copayment, as required by applicable law under any of the following:
  - Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*.
  - Immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention*.
  - With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
  - With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.
- Retroactive rescission of coverage under the policy is permitted, with 30 days advance written notice, only in the following two circumstances:
  - The individual performs an act, practice or omission that constitutes fraud.
  - The individual makes an intentional misrepresentation of a material fact.
- Other changes provided for under the *PPACA* do not impact your plan because your plan already contains these benefits. These include:
  - Direct access to OB/GYN care without a referral or authorization requirement.
  - The ability to designate a pediatrician as a primary care physician (PCP) if your plan requires a PCP designation.
  - Prior authorization is not required before you receive services in the emergency department of a hospital.

Effective for policies that are new or renewing on or after January 1, 2014, the requirements listed below apply:

If your plan includes coverage for Clinical Trials, the following applies:

The clinical trial benefit has been modified to distinguish between clinical trials for cancer and other life threatening conditions and those for non-life threatening conditions. For trials for cancer/other life threatening conditions, routine patient costs now include those for covered individuals participating in a

preventive clinical trial and Phase IV trials. This modification is optional for certain grandfathered health plans. Refer to your plan documents to determine if this modification has been made to your plan.

Pre-Existing Conditions:

Any pre-existing condition exclusions (including denial of benefit or coverage) will not apply to covered persons regardless of age.

Some Important Information about Appeal and External Review Rights under PPACA

If you are enrolled in a non-grandfathered plan with an effective date or plan year anniversary on or after September 23, 2010, the *Patient Protection and Affordable Care Act of 2010 (PPACA)*, as amended, sets forth new and additional internal appeal and external review rights beyond those that some plans may have previously offered. Also, certain grandfathered plans are complying with the additional internal appeal and external review rights provisions on a voluntary basis. Please refer to your benefit plan documents, including amendments and notices, or speak with your employer or UnitedHealthcare for more information on the appeal rights available to you. (Also, please refer to the *Claims and Appeal Notice* section of this document.)

What if I receive a denial, and need help understanding it? Please call UnitedHealthcare at the number listed on your health plan ID card.

What if I don't agree with the denial? You have a right to appeal any decision to not pay for an item or service.

How do I file an appeal? The initial denial letter or *Explanation of Benefits* that you receive from UnitedHealthcare will give you the information and the timeframe to file an appeal.

What if my situation is urgent? If your situation is urgent, your review will be conducted as quickly as possible. If you believe your situation is urgent, you may request an expedited review, and, if applicable, file an external review at the same time. For help call UnitedHealthcare at the number listed on your health plan ID card.

Generally, an urgent situation is when your health may be in serious jeopardy. Or when, in the opinion of your doctor, you may be experiencing severe pain that cannot be adequately controlled while you wait for a decision on your appeal.

Who may file an appeal? Any member or someone that member names to act as an authorized representative may file an appeal. For help call UnitedHealthcare at the number listed on your health plan ID card.

Can I provide additional information about my claim? Yes, you may give us additional information supporting your claim. Send the information to the address provided in the initial denial letter or *Explanation of Benefits*.

Can I request copies of information relating to my claim? Yes. There is no cost to you for these copies. Send your request to the address provided in the initial denial letter or *Explanation of Benefits*.

What happens if I don't agree with the outcome of my appeal? If you appeal, we will review our decision. We will also send you our written decision within the time allowed. If you do not agree with the decision, you may be able to request an external review of your claim by an independent third party. If so, they will review the denial and issue a final decision.

If I need additional help, what should I do? For questions on your appeal rights, you may call UnitedHealthcare at the number listed on your health plan ID card for assistance. You may also contact the support groups listed below.

Are verbal translation services available to me during an appeal? Yes. Contact UnitedHealthcare at the number listed on your health plan ID card. Ask for verbal translation services for your questions.

Is there other help available to me? For questions about appeal rights, an unfavorable benefit decision, or for help, you may also contact the *Employee Benefits Security Administration* at 1-866-444-EBSA (3272). Your state consumer assistance program may also be able to help you. (http://www.dol.gov.ebsa/healthreform/ - click link for Consumer Assistance Programs).

For information on appeals and other *PPACA* regulations, visit www.healthcare.gov.

If your plan includes coverage for Mental Health or Substance Use, the following applies:

Mental Health/Substance Use Disorder Parity

Effective for non-grandfathered small group Policies that are new or renewing on or after January 1, 2014, Benefits are subject to final regulations supporting the *Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)*. Benefits for mental health conditions and substance use disorder conditions that are Covered Health Services under the Policy must be treated in the same manner and provided at the same level as Covered Health Services for the treatment of other Sickness or Injury. Benefits for Mental Health Services and Substance Use Disorder Services are not subject to any annual maximum benefit limit (including any day, visit or dollar limit).

MHPAEA requires that the financial requirements for coinsurance and copayments for mental health and substance use disorder conditions must be no more restrictive than those coinsurance and copayment requirements for substantially all medical/surgical benefits. *MHPAEA* requires specific testing to be applied to classifications of benefits to determine the impact of these financial requirements on mental health and substance use disorder benefits. Based upon the results of that testing, it is possible that coinsurance or copayments that apply to mental health conditions and substance use disorder conditions in your benefit plan may be reduced.

Effective for grandfathered small group Policies that are new or renewing on or after July 1, 2010, Benefits for mental health conditions and substance use conditions that are Covered Health Services under the Policy will be revised to align prior authorization requirements and excluded services listed in your *Certificate* with Benefits for other medical conditions.

Effective for grandfathered and non-grandfathered large group Policies that are new or renewing on or after July 1, 2010, Benefits are subject to final regulations supporting the *Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)*. Benefits for mental health conditions and substance use disorder conditions that are Covered Health Services under the Policy must be treated in the same manner and provided at the same level as Covered Health Services for the treatment of other Sickness or Injury. Benefits for Mental Health Services and Substance Use Disorder Services are not subject to any annual maximum benefit limit (including any day, visit or dollar limit).

MHPAEA requires that the financial requirements for coinsurance and copayments for mental health and substance use disorder conditions must be no more restrictive than those coinsurance and copayment requirements for substantially all medical/surgical benefits. *MHPAEA* requires specific testing to be applied to classifications of benefits to determine the impact of these financial requirements on mental health and substance use disorder benefits. Based upon the results of that testing, it is possible that coinsurance or copayments that apply to mental health conditions and substance use disorder conditions in your benefit plan may be reduced.

Women's Health and Cancer Rights Act of 1998

As required by the *Women's Health and Cancer Rights Act of 1998*, Benefits under the Policy are provided for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If you are receiving Benefits in connection with a mastectomy, Benefits are also provided for the following Covered Health Services, as you determine appropriate with your attending Physician:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such Covered Health Services (including Copayments, Coinsurance and any deductible) are the same as are required for any other Covered Health Service. Limitations on Benefits are the same as for any other Covered Health Service.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under Federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g. your Physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans and issuers may not set the level of Benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under Federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of- pocket costs, you may be required to obtain precertification. For information on precertification, contact your issuer.

Claims and Appeal Notice

This Notice is provided to you in order to describe our responsibilities under Federal law for making benefit determinations and your right to appeal adverse benefit determinations. To the extent that state law provides you with more generous timelines or opportunities for appeal, those rights also apply to you. Please refer to your benefit documents for information about your rights under state law.

Benefit Determinations

Post-service Claims

Post-service claims are those claims that are filed for payment of Benefits after medical care has been received. If your post-service claim is denied, you will receive a written notice from us within 30 days of receipt of the claim, as long as all needed information was provided with the claim. We will notify you within this 30 day period if additional information is needed to process the claim, and may request a one time extension not longer than 15 days and pend your claim until all information is received.

Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, and the claim is denied, we will notify you of the denial within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied.

A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures.

If you have prescription drug Benefits and are asked to pay the full cost of a prescription when you fill it at a retail or mail-order pharmacy, and if you believe that it should have been paid under the Policy, you may submit a claim for reimbursement in accordance with the applicable claim filing procedures. If you pay a Copayment and believe that the amount of the Copayment was incorrect, you also may submit a claim for reimbursement in accordance with the applicable claim filing procedures. When you have filed a claim, your claim will be treated under the same procedures for post-service group health plan claims as described in this section.

Pre-service Requests for Benefits

Pre-service requests for Benefits are those requests that require notification or approval prior to receiving medical care. If you have a pre-service request for Benefits, and it was submitted properly with all needed information, we will send you written notice of the decision from us within 15 days of receipt of the request. If you filed a pre-service request for Benefits improperly, we will notify you of the improper filing and how to correct it within five days after the pre-service request for Benefits was received. If additional information is needed to process the pre-service request, we will notify you of the information needed within 15 days after it was received, and may request a one time extension not longer than 15 days and pend your request until all information is received. Once notified of the extension you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, we will notify you of the determination within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your request for Benefits will be denied. A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the appeal procedures.

If you have prescription drug Benefits and a retail or mail order pharmacy fails to fill a prescription that you have presented, you may file a pre-service health request for Benefits in accordance with the applicable claim filing procedure. When you have filed a request for Benefits, your request will be treated under the same procedures for pre-service group health plan requests for Benefits as described in this section.

Urgent Requests for Benefits that Require Immediate Attention

Urgent requests for Benefits are those that require notification or a benefit determination prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health, or the ability to regain maximum function or, in the opinion of a Physician with knowledge of your medical condition, could cause severe pain. In these situations, you will receive notice of the benefit determination in writing or electronically within 72 hours after we receive all necessary information, taking into account the seriousness of your condition.

If you filed an urgent request for Benefits improperly, we will notify you of the improper filing and how to correct it within 24 hours after the urgent request was received. If additional information is needed to process the request, we will notify you of the information needed within 24 hours after the request was received. You then have 48 hours to provide the requested information.

You will be notified of a benefit determination no later than 48 hours after:

- Our receipt of the requested information; or
- The end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures.

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an urgent request for Benefits as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. We will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an urgent request for Benefits and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

Questions or Concerns about Benefit Determinations

If you have a question or concern about a benefit determination, you may informally contact our *Customer Care* department before requesting a formal appeal. If the *Customer Care* representative cannot resolve the issue to your satisfaction over the phone, you may submit your question in writing. However, if you are not satisfied with a benefit determination as described above, you may appeal it as described below, without first informally contacting a *Customer Care* representative. If you first informally contact our *Customer Care* department and later wish to request a formal appeal in writing, you should again contact *Customer Care* and request an appeal. If you request a formal appeal, a *Customer Care* representative will provide you with the appropriate address.

If you are appealing an urgent claim denial, please refer to *Urgent Appeals that Require Immediate Action* below and contact our *Customer Care* department immediately.

How to Appeal a Claim Decision

If you disagree with a pre-service request for Benefits determination or post-service claim determination or a rescission of coverage determination after following the above steps, you can contact us in writing to formally request an appeal.

Your request should include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to us within 180 days after you receive the claim denial.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field, who was not involved in the prior determination. We may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information through the submission of your appeal. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records, and other information relevant to your claim for Benefits. In addition, if any new or additional evidence is relied upon or generated by us during the determination of the appeal, we will provide it to you free of charge and sufficiently in advance of the due date of the response to the adverse benefit determination.

Appeals Determinations

Pre-service Requests for Benefits and Post-service Claim Appeals

You will be provided written or electronic notification of the decision on your appeal as follows:

- For appeals of pre-service requests for Benefits as identified above, the first level appeal will be conducted and you will be notified of the decision within 15 days from receipt of a request for appeal of a denied request for Benefits. The second level appeal will be conducted and you will be notified of the decision within 15 days from receipt of a request for review of the first level appeal decision.
- For appeals of post-service claims as identified above, the first level appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for review of the first level appeal decision.

For procedures associated with urgent requests for Benefits, see *Urgent Appeals that Require Immediate Action* below.

If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. Your second level appeal request must be submitted to us within 60 days from receipt of the first level appeal decision.

Please note that our decision is based only on whether or not Benefits are available under the Policy for the proposed treatment or procedure. The decision to obtain the proposed treatment or procedure regardless of our decision is between you and your Physician.

Urgent Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health, or the ability to regain maximum function, or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your Physician should call us as soon as possible.
- We will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.

HEALTH PLAN NOTICES OF PRIVACY PRACTICES

MEDICAL INFORMATION PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Effective January 1, 2017:

We[2] are required by law to protect the privacy of your health information. We are also required to send you this notice, which explains how we may use information about you and when we can give out or "disclose" that information to others. You also have rights regarding your health information that are described in this notice. We are required by law to abide by the terms of this notice.

The terms "information" or "health information" in this notice include any information we maintain that reasonably can be used to identify you and that relates to your physical or mental health condition, the provision of health care to you, or the payment for such health care. We will comply with the requirements of applicable privacy laws related to notifying you in the event of a breach of your health information.

We have the right to change our privacy practices and the terms of this notice. If we make a material change to our privacy practices, we will provide to you, in our next annual distribution, either a revised notice or information about the material change and how to obtain a revised notice. We will provide you with this information either by direct mail or electronically, in accordance with applicable law. In all cases, if we maintain a website for your particular health plan, we will post the revised notice on your health plan website, such as www.myuhc.com. We reserve the right to make any revised or changed notice effective for information we already have and for information that we receive in the future.

UnitedHealth Group collects and maintains oral, written and electronic information to administer our business and to provide products, services and information of importance to our enrollees. We maintain physical, electronic and procedural security safeguards in the handling and maintenance of our enrollees' information, in accordance with applicable state and federal standards, to protect against risks such as loss, destruction or misuse.

How We Use or Disclose Information

We must use and disclose your health information to provide that information:

- To you or someone who has the legal right to act for you (your personal representative) in order to administer your rights as described in this notice; and
- To the *Secretary of the Department of Health and Human Services*, if necessary, to make sure your privacy is protected.

We have the right to use and disclose health information for your treatment, to pay for your health care and to operate our business. For example, we may use or disclose your health information:

- **For Payment** of premiums due us, to determine your coverage, and to process claims for health care services you receive, including for subrogation or coordination of other benefits you may have. For example, we may tell a doctor whether you are eligible for coverage and what percentage of the bill may be covered.
- **For Treatment.** We may use or disclose health information to aid in your treatment or the coordination of your care. For example, we may disclose information to your physicians or hospitals to help them provide medical care to you.

- **For Health Care Operations.** We may use or disclose health information as necessary to operate and manage our business activities related to providing and managing your health care coverage. For example, we might talk to your physician to suggest a disease management or wellness program that could help improve your health or we may analyze data to determine how we can improve our services.
- **To Provide You Information on Health Related Programs or Products** such as alternative medical treatments and programs or about health-related products and services, subject to limits imposed by law.
- **For Plan Sponsors.** If your coverage is through an employer sponsored group health plan, we may share summary health information and enrollment and disenrollment information with the plan sponsor. In addition, we may share other health information with the plan sponsor for plan administration purposes if the plan sponsor agrees to special restrictions on its use and disclosure of the information in accordance with federal law.
- **For Underwriting Purposes**. We may use or disclose your health information for underwriting purposes; however, we will not use or disclose your genetic information for such purposes.
- **For Reminders.** We may use or disclose health information to send you reminders about your benefits or care, such as appointment reminders with providers who provide medical care to you.

We may use or disclose your health information for the following purposes under limited circumstances:

- **As Required by Law.** We may disclose information when required to do so by law.
- **To Persons Involved With Your Care.** We may use or disclose your health information to a person involved in your care or who helps pay for your care, such as a family member, when you are incapacitated or in an emergency, or when you agree or fail to object when given the opportunity. If you are unavailable or unable to object, we will use our best judgment to decide if the disclosure is in your best interests. Special rules apply regarding when we may disclose health information to family members and others involved in a deceased individual's care. We may disclose health information to any persons involved, prior to the death, in the care or payment for care of a deceased individual, unless we are aware that doing so would be inconsistent with a preference previously expressed by the deceased.
- **For Public Health Activities** such as reporting or preventing disease outbreaks to a public health authority.
- **For Reporting Victims of Abuse, Neglect or Domestic Violence** to government authorities that are authorized by law to receive such information, including a social service or protective service agency.
- **For Health Oversight Activities** to a health oversight agency for activities authorized by law, such as licensure, governmental audits and fraud and abuse investigations.
- **For Judicial or Administrative Proceedings** such as in response to a court order, search warrant or subpoena.
- **For Law Enforcement Purposes.** We may disclose your health information to a law enforcement official for purposes such as providing limited information to locate a missing person or report a crime.
- **To Avoid a Serious Threat to Health or Safety** to you, another person, or the public, by, for example, disclosing information to public health agencies or law enforcement authorities, or in the event of an emergency or natural disaster.
- **For Specialized Government Functions** such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.

- **For Workers' Compensation** as authorized by, or to the extent necessary to comply with, state workers compensation laws that govern job-related injuries or illness.
- **For Research Purposes** such as research related to the evaluation of certain treatments or the prevention of disease or disability, if the research study meets federal privacy law requirements.
- **To Provide Information Regarding Decedents.** We may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as necessary to carry out their duties.
- **For Organ Procurement Purposes.** We may use or disclose information to entities that handle procurement, banking or transplantation of organs, eyes or tissue to facilitate donation and transplantation.
- **To Correctional Institutions or Law Enforcement Officials** if you are an inmate of a correctional institution or under the custody of a law enforcement official, but only if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.
- **To Business Associates** that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. Our business associates are required, under contract with us, and pursuant to federal law, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract and as permitted by federal law.
- **Additional Restrictions on Use and Disclosure.** Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about you. "Highly confidential information" may include confidential information under Federal laws governing alcohol and drug abuse information and genetic information as well as state laws that often protect the following types of information:

  1. HIV/AIDS;
  2. Mental health;
  3. Genetic tests;
  4. Alcohol and drug abuse;
  5. Sexually transmitted diseases and reproductive health information; and
  6. Child or adult abuse or neglect, including sexual assault.

If a use or disclosure of health information described above in this notice is prohibited or materially limited by other laws that apply to us, it is our intent to meet the requirements of the more stringent law. Attached to this notice is a "Federal and State Amendments" document.

Except for uses and disclosures described and limited as set forth in this notice, we will use and disclose your health information only with a written authorization from you. This includes, except for limited circumstances allowed by federal privacy law, not using or disclosing psychotherapy notes about you, selling your health information to others, or using or disclosing your health information for certain promotional communications that are prohibited marketing communications under federal law, without your written authorization. Once you give us authorization to release your health information, we cannot guarantee that the recipient to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization at any time in writing, except if we have already acted based on your authorization. To find out where to mail your written authorization and how to revoke an authorization, contact the phone number listed on your health plan ID card.

What Are Your Rights

The following are your rights with respect to your health information:

- **You have the right to ask to restrict** uses or disclosures of your information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures to family members or to others who are involved in your health care or payment for your health care. We may also have policies on dependent access that authorize your dependents to request certain restrictions. **Please note that while we will try to honor your request and will permit requests consistent with our policies, we are not required to agree to any restriction.**

- **You have the right to ask to receive confidential communications** of information in a different manner or at a different place (for example, by sending information to a P.O. Box instead of your home address). We will accommodate reasonable requests where a disclosure of all or part of your health information otherwise could endanger you. In certain circumstances, we will accept your verbal request to receive confidential communications, however; we may also require you confirm your request in writing. In addition, any requests to modify or cancel a previous confidential communication request must be made in writing. Mail your request to the address listed below.

- **You have the right to see and obtain a copy** of certain health information we maintain about you such as claims and case or medical management records. If we maintain your health information electronically, you will have the right to request that we send a copy of your health information in an electronic format to you. You can also request that we provide a copy of your information to a third party that you identify. In some cases, you may receive a summary of this health information. You must make a written request to inspect and copy your health information or have your information sent to a third party. Mail your request to the address listed below. In certain limited circumstances, we may deny your request to inspect and copy your health information. If we deny your request, you may have the right to have the denial reviewed. We may charge a reasonable fee for any copies.

- **You have the right to ask to amend** certain health information we maintain about you such as claims and case or medical management records, if you believe the health information about you is wrong or incomplete. Your request must be in writing and provide the reasons for the requested amendment. Mail your request to the address listed below. If we deny your request, you may have a statement of your disagreement added to your health information.

- **You have the right to receive an accounting** of certain disclosures of your information made by us during the six years prior to your request. This accounting will not include disclosures of information made: (i) for treatment, payment, and health care operations purposes; (ii) to you or pursuant to your authorization; and (iii) to correctional institutions or law enforcement officials; and (iv) other disclosures for which federal law does not require us to provide an accounting.

- **You have the right to a paper copy of this notice**. You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You also may obtain a copy of this notice on your health plan website, such as www.myuhc.com.

Exercising Your Rights

- **Contacting your Health Plan.** If you have any questions about this notice or want information about exercising your rights, please call the toll-free member phone number on your health plan ID card or you may contact the *UnitedHealth Group Customer Call Center* Representative at 1-866-633-2446 or TTY 711.

- **Submitting a Written Request.** You can mail your written requests to exercise any of your rights, including modifying or cancelling a confidential communication, for copies of your records, or requesting amendments to your record, to us at the following address:

UnitedHealthcare

Customer Service - Privacy Unit

PO Box 740815

Atlanta, GA 30374-0815

- **Filing a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with us at the address listed above.

You may also notify the *Secretary of the U.S. Department of Health and Human Services* of your complaint. We will not take any action against you for filing a complaint.

[2]*This Medical Information Notice of Privacy Practices applies to the following health plans that are affiliated with UnitedHealth Group: ACN Group of California, Inc.; All Savers Insurance Company; All Savers Life Insurance Company of California; AmeriChoice of Connecticut, Inc.; AmeriChoice of New Jersey, Inc.; Arizona Physicians IPA, Inc.; Care Improvement Plus of Texas Insurance Company; Care Improvement Plus South Central Insurance Company; Care Improvement Plus Wisconsin Insurance Company; Dental Benefit Providers of California, Inc.; Dental Benefit Providers of Illinois, Inc.; Golden Rule Insurance Company; Health Plan of Nevada, Inc.; MAMSI Life and Health Insurance Company; MD - Individual Practice Association, Inc.; Medical Health Plans of Florida, Inc.; Medica HealthCare Plans, Inc.; National Pacific Dental, Inc.; Neighborhood Health Partnership, Inc.; Nevada Pacific Dental; Optimum Choice, Inc.; Optum Insurance Company of Ohio, Inc.; Oxford Health Insurance, Inc.; Oxford Health Plans (CT), Inc.; Oxford Health Plans (NJ), Inc.; Oxford Health Plans (NY), Inc.; PacifiCare Life and Health Insurance Company; PacifiCare Life Assurance Company; PacifiCare of Arizona, Inc.; PacifiCare of Colorado, Inc.; PacifiCare of Nevada, Inc.; Physicians Health Choice of Texas, LLC; Preferred Care Partners, Inc.; Sierra Health and Life Insurance Company, Inc.; UHC of California; U.S. Behavioral Health Plan, California; Unimerica Insurance Company; Unimerica Life Insurance Company of New York; Unison Health Plan of Delaware, Inc.; Unison Health Plan of the Capital Area, Inc.; UnitedHealthcare Benefits of Texas, Inc.; UnitedHealthcare Community Plan of Georgia, Inc.; UnitedHealthcare Community Plan of Ohio, Inc.; UnitedHealthcare Community Plan, Inc.; UnitedHealthcare Community Plan of Texas, L.L.C.; UnitedHealthcare Insurance Company; UnitedHealthcare Insurance Company of Illinois; UnitedHealthcare Insurance Company of New York; UnitedHealthcare Insurance Company of the River Valley; UnitedHealthcare Life Insurance Company; UnitedHealthcare of Alabama, Inc.; UnitedHealthcare of Arizona, Inc.; UnitedHealthcare of Arkansas, Inc.; UnitedHealthcare of Colorado, Inc.; UnitedHealthcare of Florida, Inc.; UnitedHealthcare of Georgia, Inc.; UnitedHealthcare of Illinois, Inc.; UnitedHealthcare of Kentucky, Ltd.; UnitedHealthcare of Louisiana, Inc.; UnitedHealthcare of the Mid-Atlantic, Inc.; UnitedHealthcare of the Midlands, Inc.; UnitedHealthcare of the Midwest, Inc.; United HealthCare of Mississippi, Inc.; UnitedHealthcare of New England, Inc.; UnitedHealthcare of New Mexico, Inc.; UnitedHealthcare of New York, Inc.; UnitedHealthcare of North Carolina, Inc.; UnitedHealthcare of Ohio, Inc.; UnitedHealthcare of Oklahoma, Inc.; UnitedHealthcare of Oregon, Inc.; UnitedHealthcare of Pennsylvania, Inc.; UnitedHealthcare of Texas, Inc.; UnitedHealthcare of Utah, Inc.; UnitedHealthcare of Washington, Inc.; UnitedHealthcare of Wisconsin, Inc.; UnitedHealthcare Plan of the River Valley, Inc.*

FINANCIAL INFORMATION PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW FINANCIAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED.

PLEASE REVIEW IT CAREFULLY.

Effective January 1, 2017

We[3] are committed to maintaining the confidentiality of your personal financial information. For the purposes of this notice, "personal financial information" means information, other than health information, about an enrollee or an applicant for health care coverage that identifies the individual, is not generally publicly available and is collected from the individual or is obtained in connection with providing health care coverage to the individual.

Information We Collect

Depending upon the product or service you have with us, we may collect personal financial information about you from the following sources:

- Information we receive from you on applications or other forms, such as name, address, age, medical information and *Social Security* number;
- Information about your transactions with us, our affiliates or others, such as premium payment and claims history; and
- Information from a consumer reporting agency.

Disclosure of Information

We do not disclose personal financial information about our enrollees or former enrollees to any third party, except as required or permitted by law. For example, in the course of our general business practices, we may, as permitted by law, disclose any of the personal financial information that we collect about you without your authorization, to the following types of institutions:

- To our corporate affiliates, which include financial service providers, such as other insurers, and non-financial companies, such as data processors:
- To nonaffiliated companies for our everyday business purposes, such as to process your transactions, maintain your account(s), or respond to court orders and legal investigations; and
- To nonaffiliated companies that perform services for us, including sending promotional communications on our behalf.

Confidentiality and Security

We maintain physical, electronic and procedural safeguards in accordance with applicable state and federal standards to protect your personal financial information against risks such as loss, destruction or misuse. These measures include computer safeguards, secured files and buildings, and restrictions on who may access your personal financial information.

Questions about this Notice

If you have any questions about this notice, please call the toll-free member phone number on your health plan ID card or contact the *UnitedHealth Group Customer Call Center* at 1-866-633-2446 or TTY 711.

[3]*For purposes of this Financial Information Privacy Notice, "we" or "us" refers to the entities listed in footnote 2, beginning on the first page of the Health Plan Notices of Privacy Practices, plus the following UnitedHealthcare affiliates: Alere Women's and Children's Health, LLC; AmeriChoice Health Services,*

Inc.; Connextions HCI, LLC; LifePrint East, Inc.; Life Print Health, Inc.; Dental Benefit Providers, Inc.; gethealthinsurance.com Agency, Inc.; Golden Outlook, Inc.; HealthAllies, Inc.; MAMSI Insurance Resources, LLC; Managed Physical Network, Inc.; OneNet PPO, LLC; OptumHealth Care Solutions, Inc.; OrthoNet, LLC; OrthoNet of the Mid-Atlantic, Inc.; OrthoNet West, LLC; OrthoNet of the South, Inc.; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; Spectera, Inc.; UMR, Inc.; Unison Administrative Services, LLC; United Behavioral Health; United Behavioral Health of New York I.P.A., Inc.; United HealthCare Services, Inc.; UnitedHealth Advisors, LLC; UnitedHealthcare Service LLC; UnitedHealthcare Services Company of the River Valley, Inc. This Financial Information Privacy Notice only applies where required by law. Specifically, it does not apply to (1) health care insurance products offered in Nevada by Health Plan of Nevada, Inc. and Sierra Health and Life Insurance Company, Inc.; or (2) other UnitedHealth Group health plans in states that provide exceptions for HIPAA covered entities or health insurance products.

UNITED HEALTH GROUP

HEALTH PLAN NOTICE OF PRIVACY PRACTICES: FEDERAL AND STATE AMENDMENTS

Revised: January 1, 2017

The first part of this Notice, which provides our privacy practices for Medical Information, describes how we may use and disclose your health information under federal privacy rules. There are other laws that may limit our rights to use and disclose your health information beyond what we are allowed to do under the federal privacy rules. The purpose of the charts below is to:

1. show the categories of health information that are subject to these more restrictive laws; and
2. give you a general summary of when we can use and disclose your health information without your consent.

If your written consent is required under the more restrictive laws, the consent must meet the particular rules of the applicable federal or state law.

Summary of Federal Laws

Alcohol & Drug Abuse Information
We are allowed to use and disclose alcohol and drug abuse information that is protected by federal law only (1) in certain limited circumstances, and/or disclose only (2) to specific recipients.
Genetic Information
We are not allowed to use genetic information for underwriting purposes.

Summary of State Laws

General Health Information	
We are allowed to disclose general health information only (1) under certain limited circumstances, and /or (2) to specific recipients.	AR, CA, DE, NE, NY, PR, RI, VT, WA, WI
HMOs must give enrollees an opportunity to approve or refuse disclosures, subject to certain exceptions.	KY
You may be able to restrict certain electronic disclosures of such health information.	NC, NV
We are not allowed to use health information for certain purposes.	CA, IA
We will not use and/or disclose information regarding certain public assistance programs except for certain purposes.	KY, MO, NJ, SD
We must comply with additional restrictions prior to using or disclosing your health information for certain purposes.	KS
Prescriptions	

We are allowed to disclose prescription-related information only (1) under certain limited circumstances, and /or (2) to specific recipients.	ID, NH, NV
Communicable Diseases	
We are allowed to disclose communicable disease information only (1) under certain limited circumstances, and /or (2) to specific recipients.	AZ, IN, KS, MI, NV, OK
Sexually Transmitted Diseases and Reproductive Health	
We are allowed to disclose sexually transmitted disease and/or reproductive health information only (1) under certain limited circumstances and/or (2) to specific recipients.	CA, FL, IN, KS, MI, MT, NJ, NV, PR, WA, WY
Alcohol and Drug Abuse	
We are allowed to use and disclose alcohol and drug abuse information (1) under certain limited circumstances, and/or disclose only (2) to specific recipients.	AR, CT, GA, KY, IL, IN, IA, LA, MN, NC, NH, WA, WI
Disclosures of alcohol and drug abuse information may be restricted by the individual who is the subject of the information.	WA
Genetic Information	
We are not allowed to disclose genetic information without your written consent.	CA, CO, KS, KY, LA, NY, RI, TN, WY
We are allowed to disclose genetic information only (1) under certain limited circumstances and/or (2) to specific recipients.	AK, AZ, FL, GA, IA, MD, ME, MA, MO, NJ, NV, NH, NM, OR, RI, TX, UT, VT
Restrictions apply to (1) the use, and/or (2) the retention of genetic information.	FL, GA, IA, LA, MD, NM, OH, UT, VA, VT
HIV / AIDS	
We are allowed to disclose HIV/AIDS-related information only (1) under certain limited circumstances and/or (2) to specific recipients.	AZ, AR, CA, CT, DE, FL, GA, IA, IL, IN, KS, KY, ME, MI, MO, MT, NH, NM, NV, NY, NC, OR, PA, PR, RI, TX, VT, WA, WV, WI, WY
Certain restrictions apply to oral disclosures of HIV/AIDS-related information.	CT, FL
We will collect certain HIV/AIDS-related information only with your written consent.	OR
Mental Health	
We are allowed to disclose mental health information only (1) under certain limited circumstances and/or (2) to specific recipients.	CA, CT, DC, IA, IL, IN, KY, MA, MI, NC, NM, PR, TN, WA, WI
Disclosures may be restricted by the individual	WA

who is the subject of the information.	
Certain restrictions apply to oral disclosures of mental health information.	CT
Certain restrictions apply to the use of mental health information.	ME
Child or Adult Abuse	
We are allowed to use and disclose child and/or adult abuse information only (1) under certain limited circumstances, and/or disclose only (2) to specific recipients.	AL, CO, IL, LA, MD, NE, NJ, NM, NY, RI, TN, TX, UT, WI

Statement of Employee Retirement Income Security Act of 1974 (ERISA) Rights

As a participant in the plan, you are entitled to certain rights and protections under the *Employee Retirement Income Security Act of 1974 (ERISA)*.

Receive Information about Your Plan and Benefits

You are entitled to examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the *U.S. Department of Labor* and available at the *Public Disclosure Room* of the *Employee Benefits Security Administration*.

You are entitled to obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated *Summary Plan Description*. The Plan Administrator may make a reasonable charge for the copies.

Continue Group Health Plan Coverage

You are entitled to continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. The Plan Sponsor is responsible for providing you notice of your *Consolidated Omnibus Budget Reconciliation Act* (*COBRA)* continuation rights. Review the *Summary Plan Description* and the documents governing the plan on the rules governing your *COBRA* continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, *ERISA* imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under *ERISA*.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under *ERISA*, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for Benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the *U.S. Department of Labor*, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If

you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under *ERISA*, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the *Employee Benefits Security Administration*, *U.S. Department of Labor* listed in your telephone directory or the *Division of Technical Assistance and Inquiries*, *Employee Benefits Security Administration*, *U.S. Department of Labor*, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under *ERISA* by calling the publication hotline of the *Employee Benefits Security Administration*.

ERISA Statement

If the Enrolling Group is subject to *ERISA*, the following information applies to you.

Summary Plan Description

Name of Plan: Human Resource Associates, LLC Welfare Benefit Plan

Name, Address and Telephone Number of Plan Sponsor and Named Fiduciary:

Human Resource Associates, LLC
3250 Mary Street, Suite 400
Coconut Grove, FL 33133
(305) 448-8100

The Plan Sponsor retains all fiduciary responsibilities with respect to the Plan, except to the extent the Plan Sponsor has delegated or allocated to other persons or entities one or more fiduciary responsibilities with respect to the Plan.

Claims Fiduciary: UnitedHealthcare Insurance Company ("UnitedHealthcare," refer to your Certificate of Coverage for details on the legal entity that provides your coverage) is your Plan's Claims Fiduciary and has been delegated this responsibility by your Plan Sponsor. Your Claims Fiduciary has the authority to require eligible individuals to furnish it with information necessary for the proper administration of your Plan.

Employer Identification Number (EIN): 46-4248503

Plan Number: 501

Plan Year: November 1 through October 31

Type of Plan: Health care coverage plan

Name, Business Address, and Business Telephone Number of Plan Administrator:

Human Resource Associates, LLC
3250 Mary Street, Suite 400
Coconut Grove, FL 33133
(305) 448-8100

Type of Administration of the Plan: Your Plan is fully insured. Benefits are provided under a group insurance contract entered into between your Plan Sponsor and UnitedHealthcare. Claims for benefits are sent to UnitedHealthcare. Your employer and UnitedHealthcare share responsibility for administering the plan.

UnitedHealthcare
7600 Corporate Center Drive
Miami, FL 33126
305-715-2500

Person designated as Agent for Service of Legal Process: Plan Administrator

Discretionary Authority of Plan Administrator and Other Plan Fiduciaries: The Plan Administrator and other Plan fiduciaries shall have discretionary authority to interpret the terms of the Plan and to determine eligibility for benefits in accordance with the terms of the Plan. Any interpretation or determination made pursuant to such discretionary authority shall be given deference and be legally binding on all parties and subject to review by a legal authority only to the extent the decision was arbitrary and capricious.

Source of Contributions and Funding under the Plan: There are no contributions to the Plan. Any required employee contributions are used to partially reimburse the Plan Sponsor for Premiums under the Plan. Benefits under the Plan are funded by the payment of Premium required by the group Policy.

Method of Calculating the Amount of Contribution: Employee-required contributions to the Plan Sponsor are the employee's share of costs as determined by Plan Sponsor. From time to time, the Plan Sponsor will determine the required employee contributions for reimbursement to the Plan Sponsor and distribute a schedule of such required contributions to employees.

Qualified Medical Child Support Orders: The Plan's procedures for handling qualified medical child support orders are available without charge upon request to the Plan Administrator.

Amendment or Termination of the Plan: Your employer, as the Plan Sponsor, has the right to amend or terminate this Plan at any time. Note that the insurance contract, which is how benefits under the Plan are provided, is not necessarily the same as the Plan. As a result, termination of the insurance contract does not necessarily terminate the Plan.